

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

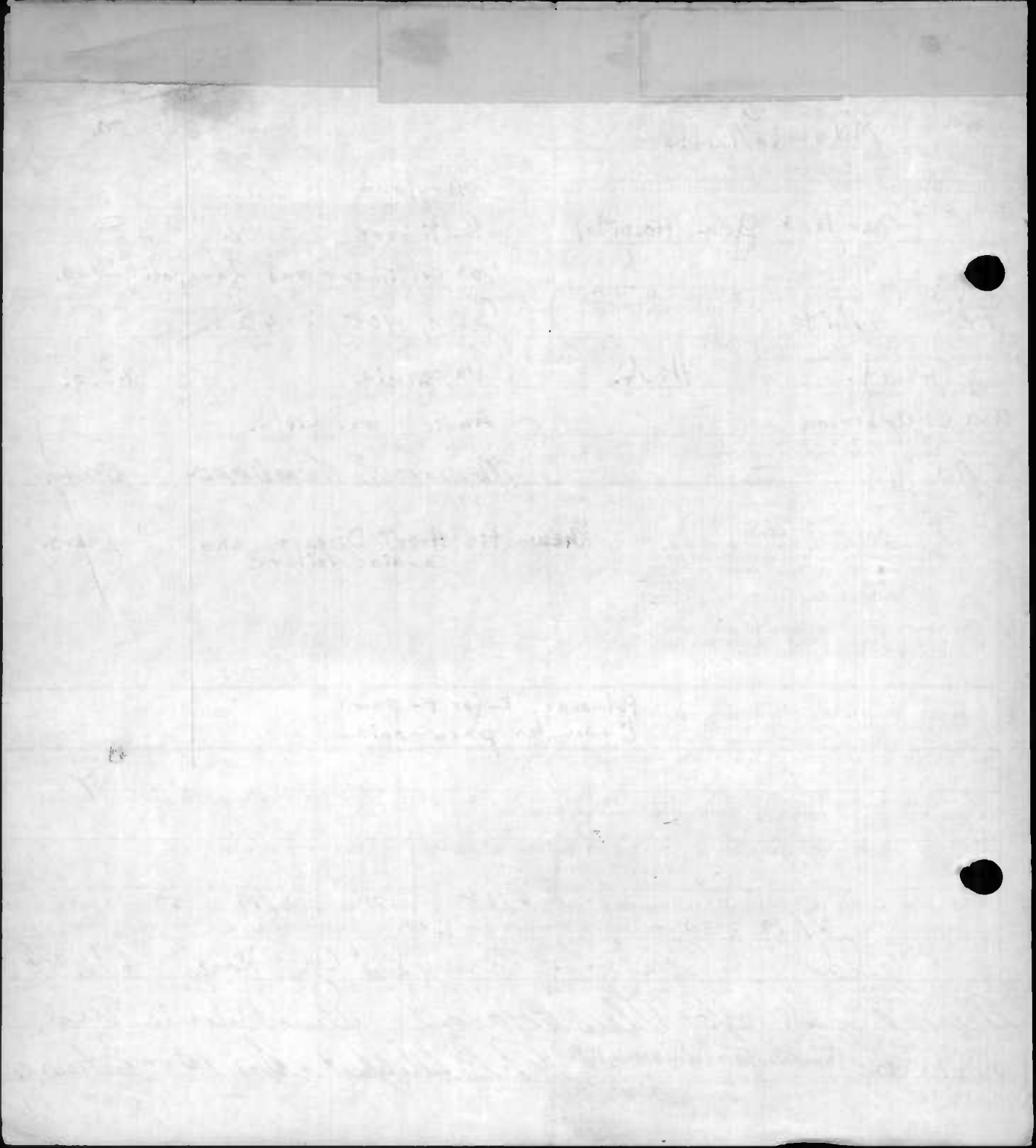
Registered No. **50 5501**

BIRTH NO. **50 5501**

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Mildred A. Numbers</i>  |                                  | 2. DATE OF DEATH<br><i>6/19/50</i>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Maryland</i><br>B. COUNTY <i>Anne Arundel</i> |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><i>Maryland Gen. Hospital</i> |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore FERNDALE</i>  |  |
| C. Length of stay in Baltimore<br>Yrs.<br>Mos.<br>Days  |                                  | D. STREET ADDRESS (If rural, give location)<br><i>708 Baltimore and Annapolis Blvd.</i>  |  |
| 5. SEX<br><i>Fe</i>   | 6. COLOR OR RACE<br><i>white</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  | 8. DATE OF BIRTH<br><i>Jan 9, 1908</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Hswf.</i>           |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Hswf.</i>  |  |
| 13. FATHER'S NAME<br><i>asa c. Anderson</i>   |                                  | 14. MOTHER'S MAIDEN NAME<br><i>Annie Warfield.</i>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>No</i>  |                                  | 16. SOCIAL SECURITY NO.<br><i>-</i>  |  |
| 17. INFORMANT<br><i>Marion C. Numbers-</i>  |                                  | ADDRESS<br><i>Same</i>   |  |

|  |  |
|--|--|
| 18. <i>416X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>CAUSE OF DEATH<br>(A) <i>Rheumatic Heart Disease and Cardiac failure</i><br>DUE TO<br><br>(B) _____<br>DUE TO<br><br>(C) _____<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><i>Pulmonary Infarct - small Broncho pneumonia</i> | INTERVAL BETWEEN ONSET AND DEATH<br><br><i>years</i> |
|--|--|

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 19A. DATE OF OPERATION<br><i>2</i>   |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that, I attended the deceased from <i>6/18</i> , 1950, to <i>6/19</i> , 1950, that I last saw the deceased alive on <i>6/19</i> , 1950, and that death occurred at <i>1:40pm.</i> , from the causes and on the date stated above. |  |  |  |   |  |
| 23A. SIGNATURE<br><i>Julda J. Tucker</i>   |  | 23B. ADDRESS<br><i>M.D. Maryland Gen. Hosp.</i>  |  | 23C. DATE SIGNED<br><i>6/19/50</i>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  |  | 24B. DATE  |  | 24C. NAME OF CEMETERY OR CREMATORY  |  |
| <i>Burial June 22 1950</i>   |  | <i>June 22 1950</i>  |  | <i>Claw Haven</i>   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUN 21 1950</i>   |  | REGISTRAR'S SIGNATURE<br><i>Wm. J. Williams</i>  |  | 25. FUNERAL DIRECTOR<br><i>F. B. Bluff</i>  |  |
|  |  |  |  | ADDRESS<br><i>1300 East Ave</i>   |  |





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 5502**

|   |  |   |  |  |  |  |  |  |  |   |  |
|---|--|---|--|--|--|--|--|--|--|---|--|
| BIRTH NO. <b>50 5502</b>  |  |   |  | 1. NAME OF DECEASED<br>(Type or Print) <b>REGINA C. HUETER</b>   |  |  |  | 2. DATE OF DEATH <b>JUNE 19-1950</b>   |  |   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |  |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY                             |  |  |  |  |  |   |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>530 S. Catherine Street</b>  |  |   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore City 20-05</b>  |  |  |  |  |  |   |  |
| C. Length of stay in Baltimore<br>Yrs.<br>Mos.<br>Days  |  |   |  | D. STREET ADDRESS (If rural, give location)<br><b>530 S. Catherine Street</b>  |  |  |  |  |  |   |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b>  |  | 8. DATE OF BIRTH<br><b>11/4/1871</b>                                       |  | 9. AGE (In years last birthday)<br><b>78</b>                                       |  | H Under 1 Year<br>Months Days<br>H Under 24 Hours<br>Hours Min. |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>  |  |  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Germany</b>                        |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                   |  |
| 13. FATHER'S NAME<br><b>George Butz</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Katherine Leidig</b>  |  |  |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>No.</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>No.</b>  |  |  |  | 17. INFORMANT ADDRESS<br><b>Lillian C. Hueter.... Same</b>                         |  |   |  |
| 18. <b>443 X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br><b>II</b><br><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  |   |  | CAUSE OF DEATH<br><br>(A) <b>Apoplexy with Right Hemiplegia 3 Days</b><br>DUE TO<br><br>(B) <b>Hypertensive Heart Disease 5 Years</b><br>DUE TO<br><br>(C) |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| 19A. DATE OF OPERATION <b>0</b>   |  |   |  | 19B. MAJOR FINDINGS OF OPERATION   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>           |  |   |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                       |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  |  |  |  |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>m. WORK AT WORK |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |  |  |   |  |
| 22. I hereby certify that I attended the deceased from <b>July 10, 1946</b> to <b>June 19, 1950</b> , that I last saw the deceased alive on <b>June 19, 1950</b> and that death occurred at <b>12:05 P.</b> from the causes and on the date stated above.   |  |   |  |  |  |  |  |  |  |   |  |
| 23A. SIGNATURE<br><b>Alfred Cole</b>  |  |   |  | 23B. ADDRESS<br><b>1934 Wilkens Ave.</b>   |  |  |  | 23C. DATE SIGNED<br><b>June 20, 1950</b>   |  |   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>June 21/50</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK CEM.</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>BALTIMORE MARYLAND</b> |  |  |  |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 21 1950</b>  |  |   |  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b>  |  |  |  | 25. FUNERAL DIRECTOR ADDRESS<br><b>E. B. WIPPERT &amp; SON.. 1300 EUTAW PL. 17</b> |  |   |  |



510  
50 5503BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5503

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| BIRTH NO.   |  | 1. NAME OF DECEASED<br>(Type or Print)   |  | 2. DATE OF DEATH  |  |
|   |  | ANNIE  |  | June 20, 1950   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |  |   |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>Johns Hopkins Hospital  |  | A. STATE<br>Maryland   |  |   |  |
| C. Length of stay in Baltimore  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 8-05   |  |   |  |
| 5. SEX<br>F   |  | 6. COLOR OR RACE<br>W  |  | D. STREET ADDRESS (If rural, give location)<br>1616 Darley Ave.                     |  |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Widowed  |  | 8. DATE OF BIRTH<br>Nov. 6, 1881   |  | 9. AGE (In years last birthday)<br>68   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>at home  |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br>Baltimore, Md.                         |  |
| 13. FATHER'S NAME<br>George Fisher  |  | 14. MOTHER'S MAIDEN NAME<br>Margaret Engle   |  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>Mrs. Harriett E. Fisher - Harcourt                                 |  |
| 18. 443X I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>Hypertensive Cardiovascular Disease<br>DUE TO<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>II<br>OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  | CAUSE OF DEATH<br>(A) Hypertensive Cardiovascular Disease<br>DUE TO<br>(B)<br>DUE TO<br>(C)  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19A. DATE OF OPERATION  |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .   |  |  |  |   |  |
| 23A. SIGNATURE<br>Stanley K. Dunder   |  | 23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input checked="" type="checkbox"/> |  | 23C. DATE SIGNED<br>June 20, 1950   |  |
| 24A. BURIAL, CREMA- TION, REMOVAL (Specify)<br>Burial   |  | 24B. DATE<br>6/23/50   |  | 24C. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer                                 |  |
| 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Md.   |  | 24E. FUNERAL DIRECTOR<br>L. J. Ruck  |  | 24F. ADDRESS<br>5305 Mayford Rd   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br>JUN 21 1950   |  | REGISTRAR'S SIGNATURE<br>Huntington Williams, M.D.   |  | ADDRESS   |  |

MEDICAL CERTIFICATION

VS 151

93D ✓

CERTIFICATE OF DEATH

I hereby certify that on the \_\_\_\_\_ day of \_\_\_\_\_  
 19\_\_\_\_ at \_\_\_\_\_  
 the deceased \_\_\_\_\_  
 was born \_\_\_\_\_  
 died \_\_\_\_\_  
 Cause of death \_\_\_\_\_  
 Signed \_\_\_\_\_  
 Registrar of Deaths

| NAME OF DECEASED | AGE   | SEX   |
|------------------|-------|-------|
| _____            | _____ | _____ |
| _____            | _____ | _____ |
| _____            | _____ | _____ |
| _____            | _____ | _____ |
| _____            | _____ | _____ |
| _____            | _____ | _____ |
| _____            | _____ | _____ |
| _____            | _____ | _____ |
| _____            | _____ | _____ |
| _____            | _____ | _____ |
| _____            | _____ | _____ |
| _____            | _____ | _____ |
| _____            | _____ | _____ |
| _____            | _____ | _____ |
| _____            | _____ | _____ |
| _____            | _____ | _____ |
| _____            | _____ | _____ |
| _____            | _____ | _____ |
| _____            | _____ | _____ |

326  
50 5504BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5504  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Charles J. Rodgers

2. DATE  
OF  
DEATH

June 19th. 1950

3. PLACE OF DEATH:

A. Baltimore City. Maryland Baltimore

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

720 Belgian Ave.

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

3/27th./1890

9. AGE (in years  
last birthday)

60

11 Under 1 Year  
Months Days11 Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Optometrist

10B. KIND OF BUSINESS OR  
INDUSTRY

Optical

11. BIRTHPLACE (State or foreign country)

England

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Hugh Rodgers

14. MOTHER'S MAIDEN NAME

Anna Boyle

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

212-01-6396 Mrs. L. S. Lemkull 1106 E. 36th. St

17. INFORMANT

ADDRESS

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Carcinomatosis

4 mo

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Carcinoma of Pancreas.

7 mo.

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

March 19, 1950

19B. MAJOR FINDINGS OF OPERATION

Ca. of pancreas c metastases to liver

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1950 to June 19, 1950, that I last saw the  
deceased alive on June 19, 1950, and that death occurred at 2:10 Pm., from the causes and on the date stated above.

23A. SIGNATURE

Norman R. Freeman, M.D.

23B. ADDRESS

11 W. 29th St.

23C. DATE SIGNED

June 20, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

6/22/1950

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION (City, town, or county)

Baltimore

Md.

DATE RECEIVED BY  
LOCAL REGISTRY

REGISTRAR'S SIGNATURE

JUN 21 1950

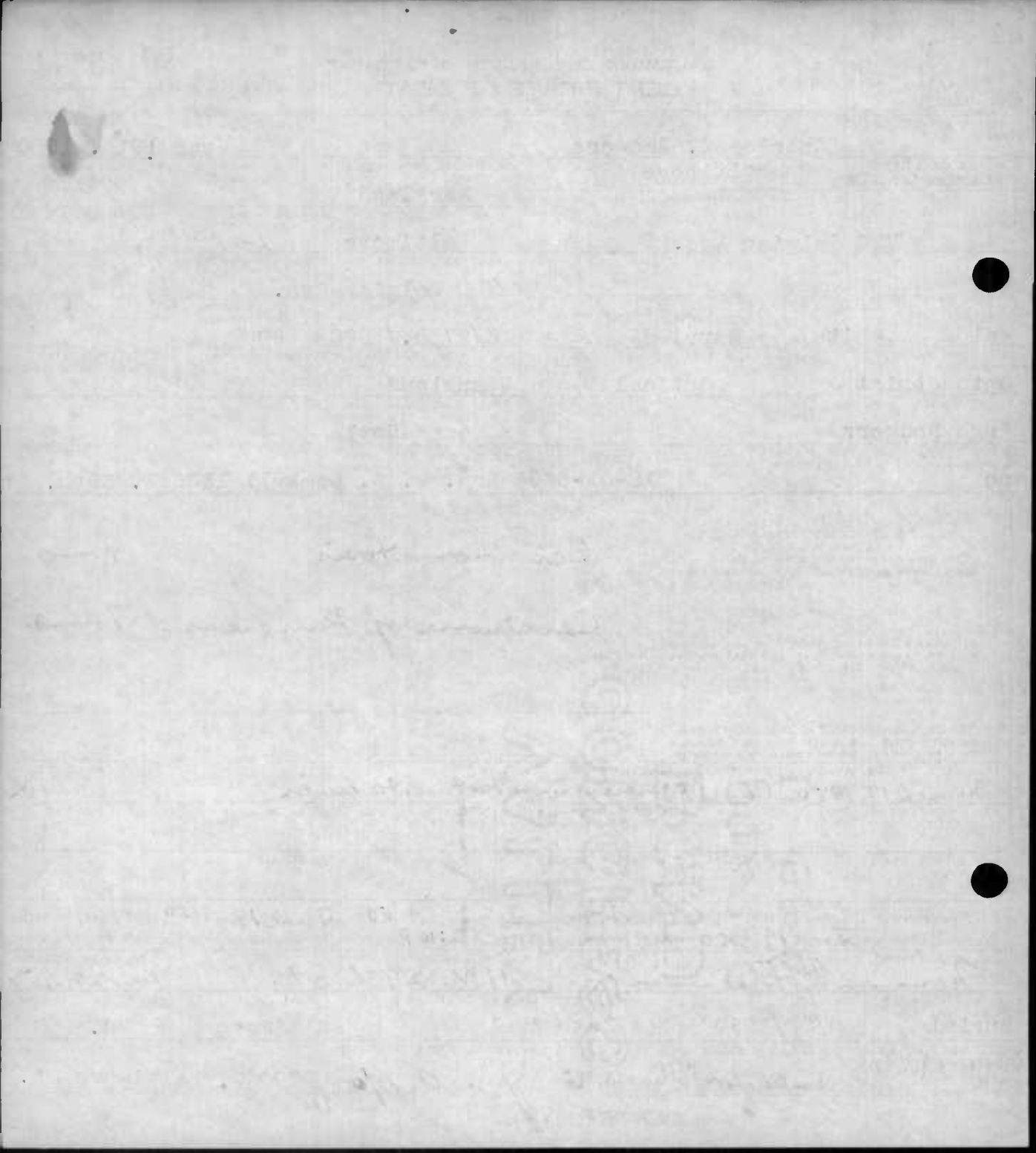
Huntington Williams, M.D.

25. FUNERAL DIRECTOR

John A. M. J. M.

ADDRESS

3000 E. Baltimore St.





520  
50 5505

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5505  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print) *Annie Dirmick*

2. DATE OF DEATH *June 19/50*

3. PLACE OF DEATH:  
A. Baltimore City, Maryland *Baltimore Md*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE *MD* B. COUNTY *Baltimore*

5. FULL NAME OF HOSPITAL OR INSTITUTION *902 S Baylis St*

6. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)  
*Baltimore*

7. STREET ADDRESS (If rural, give location)  
*902 S Baylis St 26-09*

8. LENGTH OF STAY IN BALTIMORE *Life*

9. SEX *Female*

10. COLOR OR RACE *White*

11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
*Widowed*

12. DATE OF BIRTH *Nov 26 8/1885*

13. AGE (In years last birthday) *64*

14. Under 1 Year Months: Days

15. Under 24 Hours Hours: Min.

16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
*at home*

17. KIND OF BUSINESS OR INDUSTRY

18. BIRTHPLACE (State or foreign country)  
*Baltimore*

19. CITIZEN OF WHAT COUNTRY?

20. FATHER'S NAME *John Barthel*

21. MOTHER'S MAIDEN NAME *Christine Burge dine*

22. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

23. SOCIAL SECURITY NO.

24. INFORMANT *Anna Mitchell 813 Eaton St*

25. ADDRESS

18. *442X*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

INTERVAL BETWEEN ONSET AND DEATH *2 yr.*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) *My persistent Cardiac Valvular Disease*

DUE TO *Chronic Supraventricular Abnormalities*

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION *0*

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *1/14/1950* to *6/19/1950*, that I last saw the deceased alive on *6/18/1950*, and that death occurred at *7:15 p.m.* from the causes and on the date stated above.

23A. SIGNATURE *Dr. Stephen F. Kunkawa* M. D.

23B. ADDRESS *10168 East Ave*

23C. DATE SIGNED *6/20/50*

24A. BURIAL, CREMATION, REMOVAL (Specify) *Coke Lawn*

24B. DATE *June 21-*

24C. NAME OF CEMETERY OR CREMATORY *Coke Lawn Ceme*

24D. LOCATION (City, town, or county) (State) *City*

DATE RECEIVED BY LOCAL REGISTRAR *JUN 21 1950*

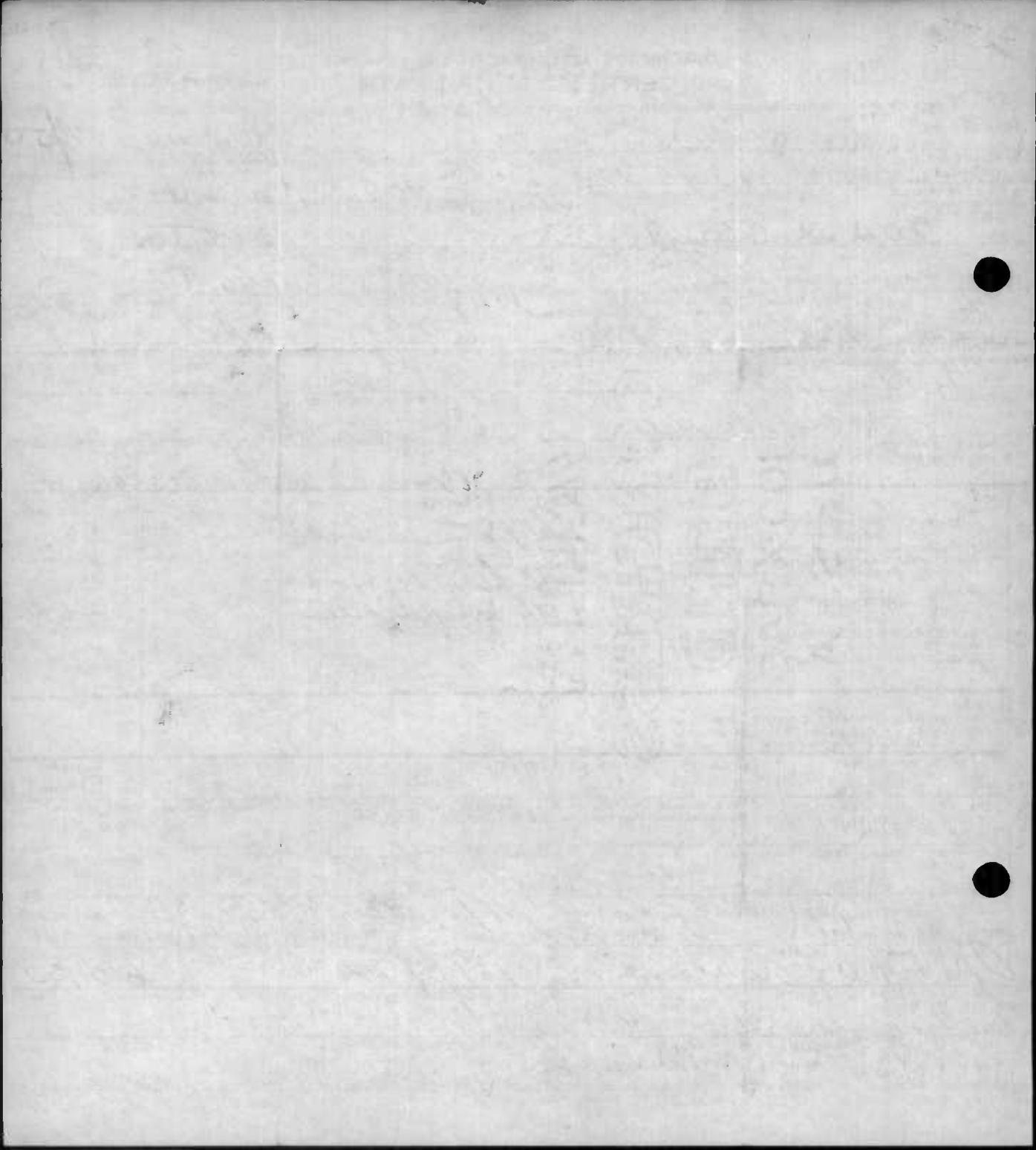
REGISTRAR'S SIGNATURE *Wilmington Williams, M.D.*

25. FUNERAL DIRECTOR *Wolfe's Funeral Homes*

ADDRESS

93D





246  
50 5506

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5506  
Registered No. 50-5506

|  |  |   |  |
|--|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print)   |  | 2. DATE OF DEATH  |  |
| Blanche D. Iglehart  |  | June 20, 1950   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE<br>Maryland |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>5215 Tramore Rd.  |  | B. COUNTY<br>Baltimore  |  |
| C. CITY OR TOWN<br>Baltimore   |  | D. STREET ADDRESS (If rural, give location)<br>5215 Tramore Rd.   |  |
| 5. SEX<br>female   |  | 6. DATE OF BIRTH<br>July 27, 1885   |  |
| 6. COLOR OR RACE<br>white  |  | 9. AGE (In years last birthday)<br>64   |  |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>married   |  | 10. UNDER 1 Year Months: Days: Hours: Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>housewife |  | 10B. KIND OF BUSINESS OR INDUSTRY<br>at home  |  |
| 11. BIRTHPLACE (State or foreign country)<br>Ohio  |  | 12. CITIZEN OF WHAT COUNTRY?<br>Ohio  |  |
| 13. FATHER'S NAME<br>John Deavers  |  | 14. MOTHER'S MAIDEN NAME<br>Harriett Booze  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br>no                                  |  | 16. SOCIAL SECURITY NO.<br>no   |  |
| 17. INFORMANT<br>Mr. Ralph Iglehart  |  | ADDRESS<br>2709 Classen Ave.  |  |

|   |  |                                  |
|---|--|----------------------------------|
| 18. CAUSE OF DEATH  |  | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>Chronic myocarditis -Diabetes Mellitus |  | months                           |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B)<br>(C)  |  |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONOITION CAUSING IT.   |  |                                  |

|  |  |  |  |  |
|--|--|--|--|--|
| 19A. DATE OF OPERATION<br>0  |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |
| 22. I hereby certify that I attended the deceased from 3-1-1950 to 6-20-1950, that I last saw the deceased alive on 6-20-1950, and that death occurred at 12:30 PM from the causes and on the date stated above. |  |  |  |  |
| 23A. SIGNATURE<br>Rylee W. Golley  |  | 23B. ADDRESS<br>5103 Harford Rd.   |  | 23C. DATE SIGNED<br>6-20-50  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 24B. DATE<br>6-24-50   |  | 24C. NAME OF CEMETERY OR CREMATORY<br>Moreland Mem. Park                 |
| 24D. LOCATION (City, town, or county)<br>Balto., Md.   |  | 24E. DATE RECEIVED BY LOCAL REGISTRAR<br>6-21-50   |  | 24F. REGISTRAR'S SIGNATURE<br>Huntington Williams, M.D.                  |
| 24G. FUNERAL DIRECTOR<br>Wm. J. Tickner & Sons   |  | 24H. ADDRESS<br>Balto., Md.  |  | 24I. VS 150  |

61✓

RECEIVED

DATE

AT

BY

FOR

10-10-01

RECEIVED

DATE

AT

BY

FOR

10-10-01

DATE

AT

BY

FOR

10-10-01

DATE

AT

BY

FOR

10-10-01

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5507  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

CHARLES D. FERREE

2. DATE  
OF  
DEATH

June 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  
3111 Brighton St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 16-07

D. STREET ADDRESS (If rural, give location)  
3111 Brighton St.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
Widowed

8. DATE OF BIRTH

Sept. 8, 1869

9. AGE (In years last birthday)

80

10. Under 1 Year Months Days 11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Owner (retired)

10B. KIND OF BUSINESS OR INDUSTRY

Grocery

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Alexander Ferree

14. MOTHER'S MAIDEN NAME

Caroline Clemens

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
no

16. SOCIAL SECURITY NO.  
no

17. INFORMANT ADDRESS  
Mrs. Clarence Grempler 3111 Brighton St.

18. 422.1 163X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

Acute Cardiac Failure

1 day

DUE TO

Arteriosclerotic Cardiovascular Disease

5 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Carcinoma of Lung

2 months

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 4/10, 1950, to 6/18, 1950, that I last saw the deceased alive on 6/18, 1950, and that death occurred at 8:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Joseph L. Lantieri M. D.

676 Washington Blvd

6/20/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

6/22/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cem.

24D. LOCATION (City, town, or county) (State)

Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUN 21 1950

Wilmington Williams, MD

Blk of J. Lickner & Sons - Balto

MEDICAL CERTIFICATION

RECEIVED THE OFFICE OF THE  
DIRECTOR OF THE BUREAU OF  
THE ARMY



516  
50 5508BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5508

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| BIRTH NO.  |  | 1. NAME OF DECEASED<br>(Type or Print) JULIA R. JENIFER   |  | 2. DATE OF DEATH 6-17-50   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>Baltimore Md</i>  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Md</i> B. COUNTY |  |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION <i>BAR-WILBA</i><br><i>2101 Cold Spring Lane.</i>  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 15-01</i>                |  |  |  |
| D. STREET ADDRESS (If rural, give location)<br><i>1608 Vincent St.</i>   |  | 5. SEX <i>F</i> 6. COLOR OR RACE <i>Col</i> 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>W</i>                  |  |  |  |
| 8. DATE OF BIRTH <i>Feb. 6, 1885</i>   |  | 9. AGE (In years last birthday) <i>65</i>   |  | 10. UNDER 1 Year Months: Days 11. UNDER 24 Hours Hours: Min.                     |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>  |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>                     |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 13. FATHER'S NAME<br><i>Wheathley Reed</i>  |  | 14. MOTHER'S MAIDEN NAME<br><i>Unknown</i>                                       |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>no</i>   |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT <i>Joseph A. Jenifer</i> ADDRESS <i>246 W. 127 St. Mt. Vernon</i>  |  |
| 18. <i>443 X</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>DUE TO (A) <i>Hypertensive Heart.</i><br>DUE TO (B)<br>DUE TO (C) |  | CAUSE OF DEATH  |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>1 year</i>                                |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |   |  |  |  |
| 19A. DATE OF OPERATION <i>0</i>  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                              |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)         |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <i>5-24-1950</i> to <i>6-17-1950</i> , that I last saw the deceased alive on <i>6-16-1950</i> , and that death occurred at <i>3:20 P.m.</i> , from the causes and on the date stated above.                                     |  |   |  |  |  |
| 23A. SIGNATURE <i>George C. Heger</i>  |  | 23B. ADDRESS <i>M.D. 1816 N. Mount St.</i>  |  | 23C. DATE SIGNED <i>6-17-50</i>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>  |  | 24B. DATE <i>6-23-50</i>  |  | 24C. NAME OF CEMETERY OR CREMATORY <i>Mount Auburn</i>                           |  |
| 24D. LOCATION (City, town, or county) <i>Md</i>  |  | 25. FUNERAL DIRECTOR <i>Huntington Williams, M.D.</i>   |  | ADDRESS <i>1307 Chestnut St</i>  |  |

CERTIFICATE OF DEATH

LAST NAME FIRST MIDDLE INITIAL

1





ES-137824

CERTIFICATE CORRECTED

2-22-50

50 5509

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Herbert Lewis Pegram</b>  |                                  | 2. DATE OF DEATH <b>6-19-50</b>  |   |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>  |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence)<br>A. STATE <b>(Md) Virginia</b> B. COUNTY <b>- 4 -</b> before admission) |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Baltimore City Hospitals</b>                                    |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>(Baltimore) Richmond</b>                                    |   |
| C. Length of stay in Baltimore <b>6 Yrs.</b>  |                                  | D. STREET ADDRESS (If rural, give location)<br><b>(Md.-State Penitentiary) 2223 Main St.</b>   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Negro</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Single</b>   | 8. DATE OF BIRTH<br><b>Sept. 3, 1907</b>  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>   | 9. AGE (In years last birthday) <b>42</b> |
| 13. FATHER'S NAME<br><b>Daniel Pegram</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>Va.</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>no</b>                                |                                  | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT<br><b>William Pegram - 2223 Main St. Richmond, Va.</b>  |                                  | 18. INTERVAL BETWEEN ONSET AND DEATH   |   |

|  |  |                                  |
|--|--|----------------------------------|
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Generalized Carcinomatosis</b> |  | INTERVAL BETWEEN ONSET AND DEATH |
| (A) DUE TO   |  |                                  |
| (B) <b>Carcinoma of Stomach</b>  |  |                                  |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(C)  |  |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |                                  |

|  |   |  |  |   |
|--|---|--|--|---|
| 19A. DATE OF OPERATION<br><b>5-17-50</b>   |   | 19B. MAJOR FINDINGS OF OPERATION<br><b>Carcinoma of Stomach</b>          |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |   |
| 22. I hereby certify that I attended the deceased from <b>5-5-</b> , 19 <b>50</b> , to <b>6-19</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>6-19</b> , 19 <b>50</b> , and that death occurred at <b>1:45 A.M.</b> from the causes and on the date stated above. |   |  |  |   |
| 23A. SIGNATURE<br><b>C. S. Rogers</b>  |   | 23B. ADDRESS<br><b>4940 Eastern Avenue</b>                               |  | 23C. DATE SIGNED<br><b>6-19-50</b>  |

|  |                             |  |   |
|--|-----------------------------|--|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Buried</b> | 24B. DATE<br><b>June 24</b> | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Mr. Latis P. Walleris</b> | 24D. LOCATION (City, town, or county) (State)<br><b>Richmond - VA</b> |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>Richmond VA</b>     |                             | 25. FUNERAL DIRECTOR<br><b>3227 S. Chedoke St.</b>                 |   |

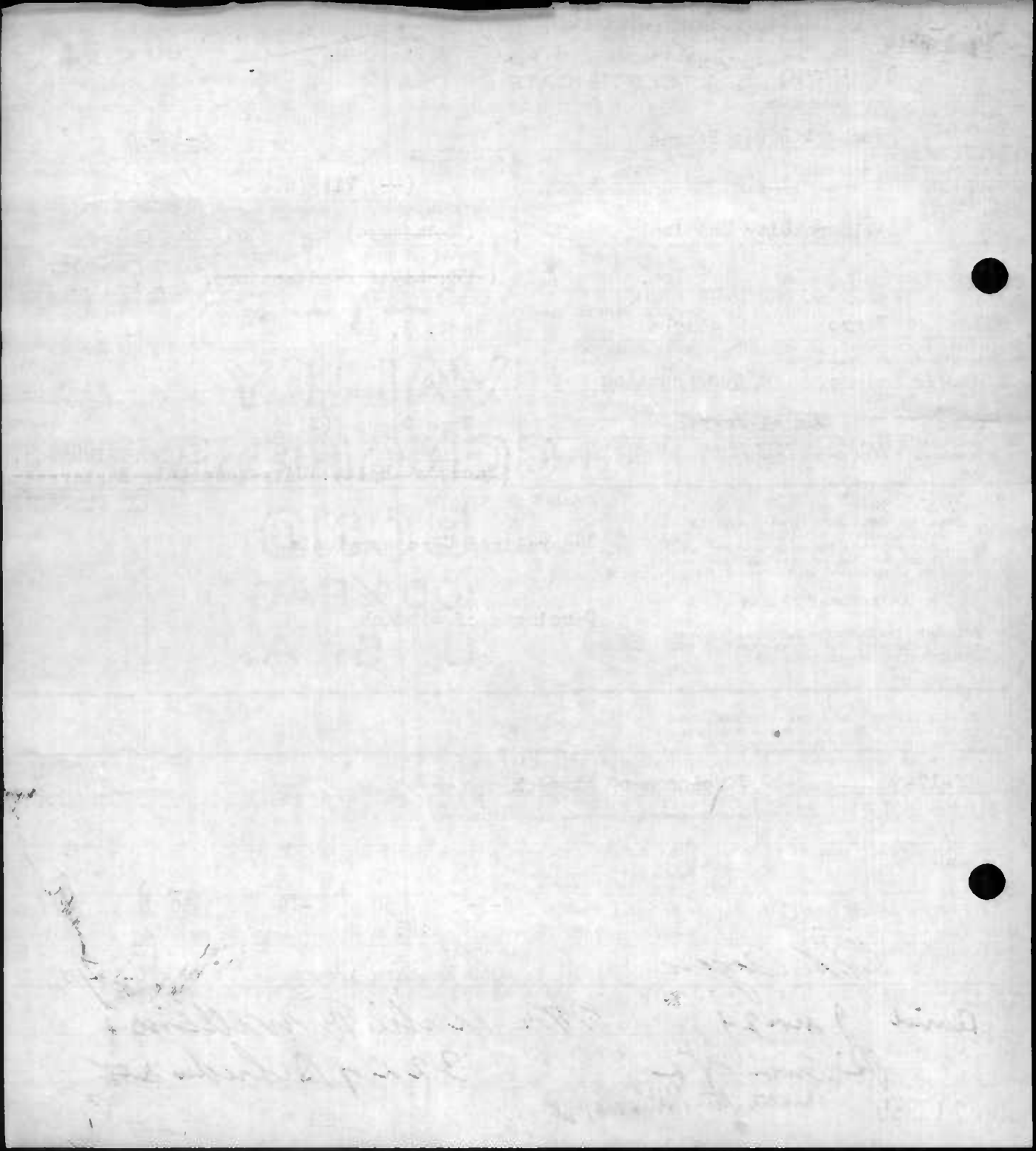
JUN 21 1950

Huntington Williams, Md

988V9

46B

MEDICAL CERTIFICATION



B-650  
50 5510BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5510  
Registered No.

BIRTH NO.

|   |                                  |  |                                    |
|---|----------------------------------|--|------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>ARMOND V BROWN</b>  |                                  | 2. DATE OF DEATH <b>June 18, 1950</b>  |                                    |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |                                    |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>South Baltimore General Hospital</b> |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>12-03</b>                  |                                    |
| C. Length of stay in Baltimore <b>34 years</b><br>Yrs. <b>34</b><br>Mos. <b>0</b><br>Days <b>0</b>                              |                                  | D. STREET ADDRESS (If rural, give location)<br><b>403 Lorraine Avenue</b>  |                                    |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>married</b>  | 8. DATE OF BIRTH<br><b>9/23/15</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clumber Helper</b>            |                                  | 9. AGE (In years last birthday)<br><b>34</b><br>H Under 1 Year<br>Months: Days: H Under 24 Hours<br>Hours: Min.                |                                    |
| 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Hunting</b>   |                                  | 11. BIRTHPLACE (State or foreign country)<br><b>Bath Md</b>  |                                    |
| 13. FATHER'S NAME<br><b>Fake Brown</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?   |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>#2</b>           |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Sofia Brown</b>   |                                    |
| 16. SOCIAL SECURITY NO.   |                                  | 17. INFORMANT ADDRESS  |                                    |

|   |                |                                  |
|---|----------------|----------------------------------|
| 18. <b>E 914.3</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>Aspiration of vomitus</b><br>DUE TO <b>electrocution</b> | CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  | (B)<br>DUE TO  |                                  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   | (C)<br>DUE TO  |                                  |

|   |  |  |  |   |
|---|--|--|--|---|
| 19A. DATE OF OPERATION  |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   | 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)<br><b>Industrial Plant</b> | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>Revere Copper &amp; Brass Co., 1301 Wicomco St.</b> |  |   |
| 21D. TIME (Month) (Day) (Year) (Hour)<br><b>June 18, 1950 1:15 P. m.</b>  | 21E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>    | 21F. HOW DID INJURY OCCUR?<br><b>Electrocuted by touching an overhead wire &amp; fell to floor from top of 18 ft. ladder</b>       |  |   |
| 22. I certify that I took charge of the remains described above, held an <b>Autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |  |  |  |   |
| 23A. SIGNATURE<br><b>Stanley H. Duncanson</b> M.D.  |  | 23B. CHIEF MEDICAL EXAMINER.....<br>ASSISTANT MEDICAL EXAMINER.....<br>MEDICAL INVESTIGATOR.....                                   |  | 23C. DATE SIGNED<br><b>June 19, 1950</b>  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Buried</b>  | 24B. DATE<br><b>June 22-50</b>   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Bath Memorial</b>   | 24D. LOCATION (City, town, or county) (State)<br><b>5200 Federal Ave</b> |   |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 21 1950</b>  |  | 25. FUNERAL DIRECTOR<br><b>Bay View Mortuary</b> ADDRESS <b>193</b>  |  |   |
| V S 151 <b>N-902X- 98AV9 403-E-2554</b>   |  |  |  |   |

REPORT OF THE HEALTH DEPARTMENT  
DEPARTMENT OF HEALTH

REPORT OF THE HEALTH DEPARTMENT

LC 5-162  
9250450 5511

CERTIFICATE CORRECTED 8-22-50

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

X 50 5511  
Registered No.

BIRTH NO.

|   |  |  |  |
|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Jane Sprague</b>   |  | 2. DATE OF DEATH<br><b>June 20, 1950</b>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>Baltimore City Hospitals</b><br><b>4940 Eastern Avenue</b> |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>   |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>   |  |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b>   |  | 8. DATE OF BIRTH<br><b>June 4, 1869</b>  |  |
| 9. AGE (In years last birthday)<br><b>81</b>  |  | 10. UNDER 1 Year: Months <b>5</b> Days <b>30</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |
| 13. FATHER'S NAME<br><b>John Hansdoffer (D)</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Taylor (D)</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>Yes, no or unknown</b>  |  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT<br><b>Baltimore City Hospitals</b><br><b>Records* 4940 Eastern Avenue</b>   |  | ADDRESS  |  |

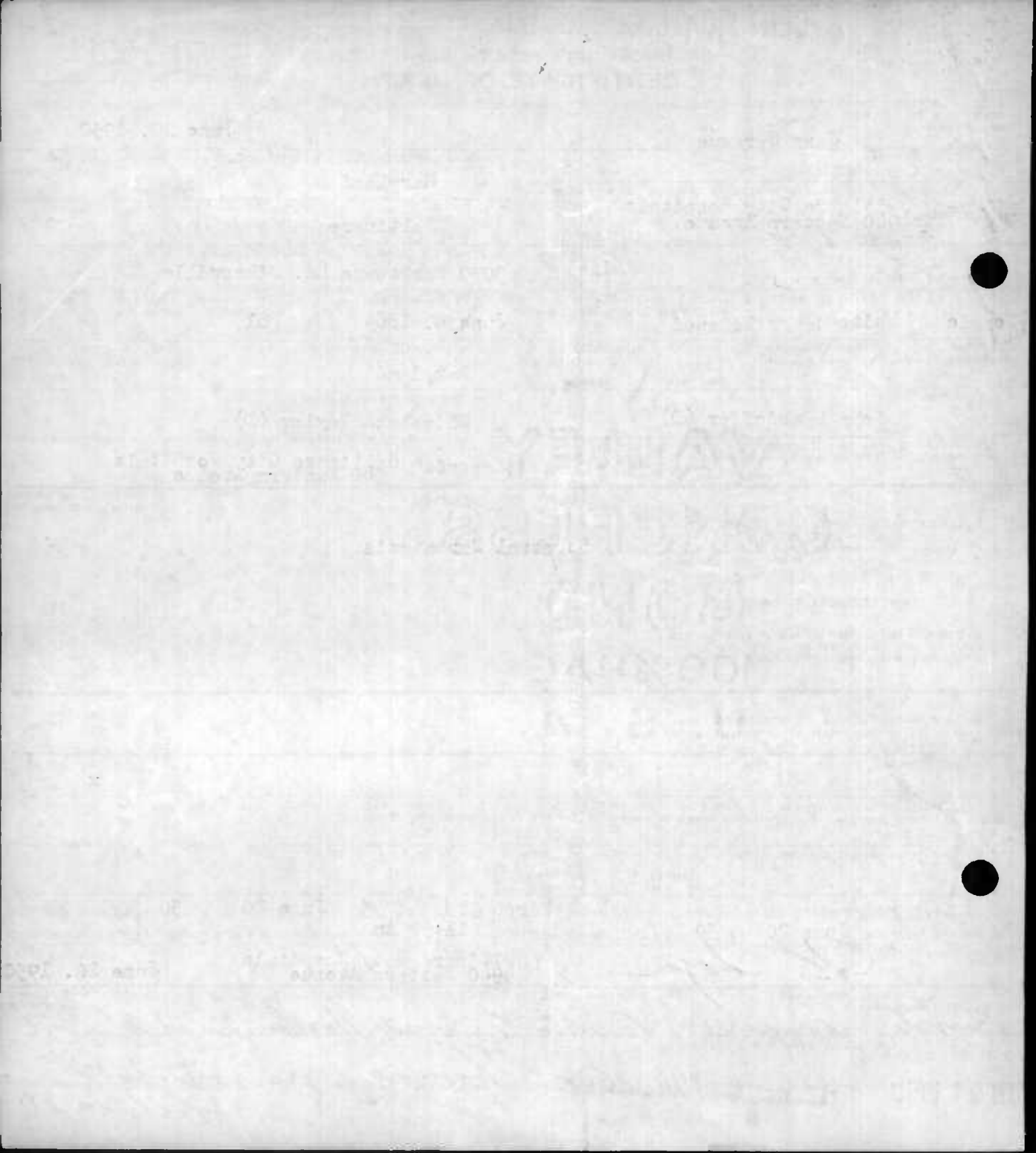
|   |  |                                  |
|---|--|----------------------------------|
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cerebral Thrombosis</b> |  | INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO (A) <b>Cerebral Thrombosis</b>   |  |                                  |
| DUE TO (B) <b>Cerebral Thrombosis</b>   |  |                                  |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO (C) <b>Cerebral Thrombosis</b>   |  |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |                                  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 19A. DATE OF OPERATION<br><b>June 20, 1950</b>  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br><input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Home</b>  |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)         |  |
| 21D. TIME (Month) (Day) (Year) (Hour) (Minute)<br><b>June 20, 1950, 11:30 AM</b>  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?<br><b>Stroke</b>   |  |
| 22. I hereby certify that I attended the deceased from <b>March 8, 1945</b> to <b>June 20, 1950</b> that I last saw the deceased alive on <b>June 20, 1950</b> , and that death occurred at <b>11:30 AM</b> from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE<br><b>R. J. Cozen</b>  |  | M. D.<br><b>Baltimore City Hospitals</b><br><b>4940 Eastern Avenue</b>                                    |  | 23C. DATE SIGNED<br><b>June 20, 1950</b>  |  |

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> |  | 24B. DATE<br><b>June 22</b>                               |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cemetery</b> |  | 24D. LOCATION (City, town, or county) (State)<br><b>North Ave at Hollins</b> |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>June 21, 1950</b>   |  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b> |  | 25. FUNERAL DIRECTOR<br><b>Thomas J. Kennedy</b>                |  | ADDRESS<br><b>1600 Hollins St</b>  |  |

UN 21 1950

8212 Hollins St





K-540  
50 5512BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHX 50 5512  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM. A. Kneel

2. DATE  
OF  
DEATH

6/21/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Maryland Gen. Hosp.

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE

Maryland

COUNTY

before admission)

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

5300

D. STREET ADDRESS (If rural, give location)

4329 Allen Drive #29

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months Days  
If Under 24 Hours  
Hours Min.

10. USUAL OCCUPATION (If deceased was a professional, give full title, and if life, give title)

11. KIND OF BUSINESS OR  
INDUSTRY12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 443X  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) .....  
DUE TO

CAUSE OF DEATH

Cerebral Hemorrhage

INTERVAL BETWEEN  
ONSET AND DEATH

1 day

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) .....  
DUE TOHypertensive heart  
disease

(C) .....

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/19, 1950, to 6/21, 1950, that I last saw the  
deceased alive on 6/21, 1950, and that death occurred at 12:49 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUN 21 1950

Huntington Williams, M.D.

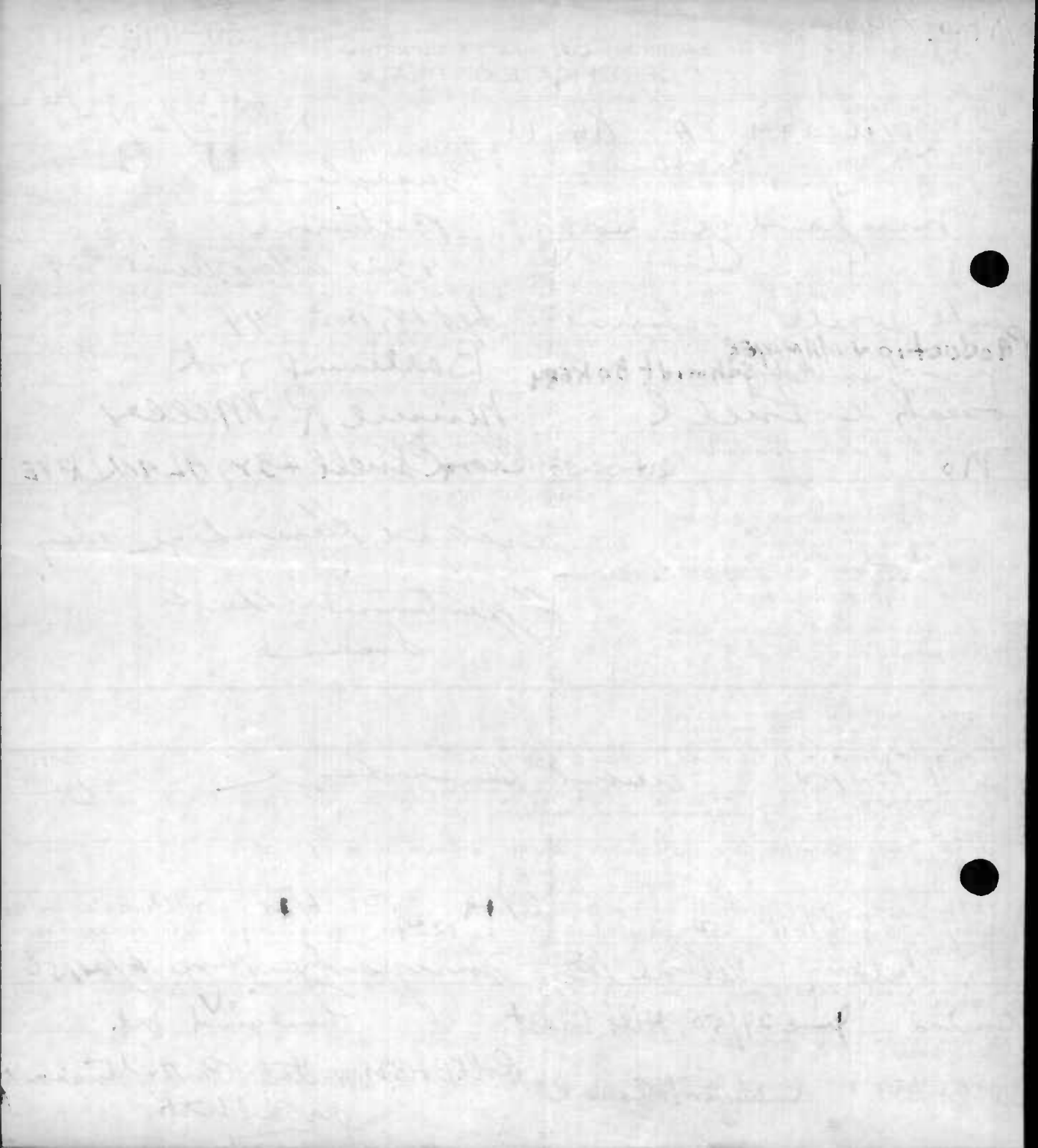
156 XV

Rolt. C. &amp; B. M. Walters Pratt &amp; Strickland

Rev Paul Smith

937





R-230

50 5513

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5513  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Hannah Rist

2. DATE  
OF  
DEATH

June 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

2314 Aiken St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore -18

9-08

D. STREET ADDRESS (If rural, give location)

2314 Aiken St.

C. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Oct. 27, 1881

9. AGE (in years  
last birthday)

68

If Under 1 Year  
Months; DaysIf Under 24 Hours  
Hours; Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry Holland

14. MOTHER'S MAIDEN NAME

Marion Thorwood

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

216-10-3826a

17. INFORMANT

ADDRESS

Mr. Conrad Rist 2314 Aiken St.

18. 420.1 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

Cormay Thrombosis

DUE TO

4 hrs.

## ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK22. I hereby certify that I attended the deceased from 6/19/1950 to 6/19/1950, that I last saw the  
deceased alive on 6/19/1950, and that death occurred at 3:40 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Marion Guedra

M. D.

23B. ADDRESS

1737 E. North Avenue

23C. DATE SIGNED

6/20/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

June 22, 1950

24C. NAME OF CEMETERY OR CREMATORY

Baltimore Cem.

24D. LOCATION (City, town, or county) (State)

Baltimore Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

H. Sander &amp; Sons, Inc.

25. FUNERAL DIRECTOR

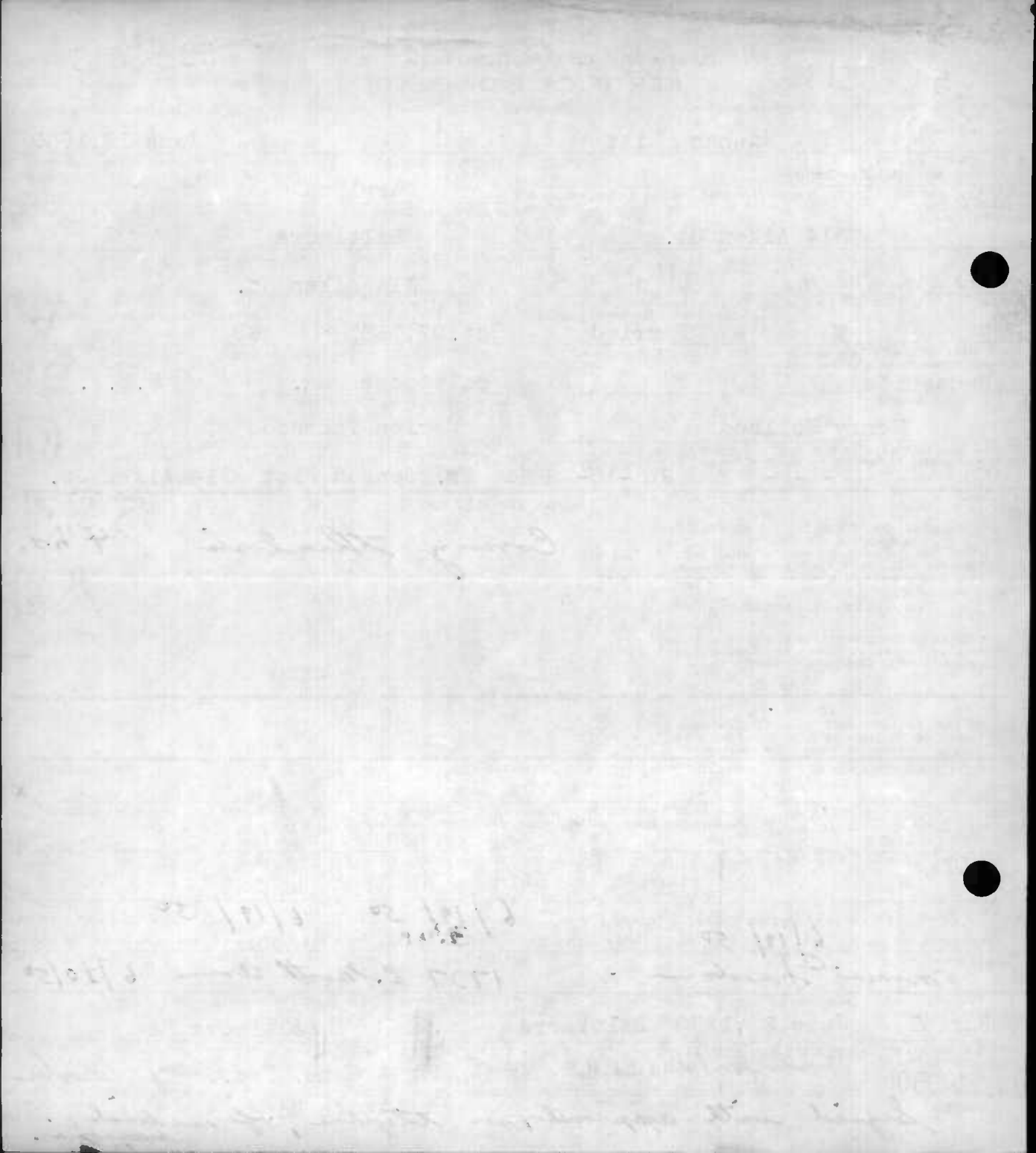
ADDRESS

H. Sander &amp; Sons, Inc. 94a

JUN 21 1950

VS 150

Signed with approval, per telephone, of medical examiner.



H-643

50 5514

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5514  
Registered No.

|  |                                  |   |  |  |   |
|--|----------------------------------|---|--|--|---|
| BIRTH NO.  |                                  | 1. NAME OF DECEASED<br>(Type or Print) <b>Mr. George C. Herold</b>  |  | 2. DATE OF DEATH <b>June 20, 1950</b>  |   |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>   |                                  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>Baltimore</b> |  |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>St. Joseph's Hospital</b>  |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>  |  |  |   |
| C. Length of stay in Baltimore <b>life</b>   |                                  | D. STREET ADDRESS (If rural, give location)<br><b>408 S. East Avenue - 24</b>   |  |  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>   | 8. DATE OF BIRTH<br><b>Apr. 27, 1877</b> | 9. AGE (In years last birthday)<br><b>73</b>   | 10. Under 1 Year Months: Days<br>11. Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired 4 Yrs.</b>   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Salesman - Brewery</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore</b>                        |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                  | 13. FATHER'S NAME<br><b>George D. Herold</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary ?</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>214-01-6592</b>   |  | 17. INFORMANT ADDRESS<br><b>Mrs. Katherine M. Herold (Wife)<br/>408 S. East Ave.</b> |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Dissecting aneurysm of arch of aorta</b>                               |                                  | CAUSE OF DEATH<br><b>Arteriosclerosis</b>   |  | INTERVAL BETWEEN ONSET AND DEATH   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |                                  | (B) DUE TO  |  |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                                  | (C) <b>Bilateral tumor of kidneys with metastases to lungs</b>  |  | <b>over</b>  |   |
| 19A. DATE OF OPERATION<br><b>4-5-1X</b>  |                                  | 19B. MAJOR FINDINGS OF OPERATION<br><b>Arteriosclerosis, left apex</b>  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)             |   |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   |                                  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <b>6/16/</b> , 19 <b>50</b> to <b>6/20/</b> , 19 <b>50</b> that I last saw the deceased alive on <b>6/20/</b> , 19 <b>50</b> , and that death occurred at <b>1:00 PM.</b> , from the causes and on the date stated above. |                                  |   |  |  |   |
| 23A. SIGNATURE<br><b>Maddeu Sawinski</b>   |                                  | 23B. ADDRESS<br><b>M. D. 1400 N. Caroline St.</b>   |  | 23C. DATE SIGNED<br><b>6/20/50</b>   |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 24B. DATE<br><b>June 23, '50</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cemetery</b>                      |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Md.</b>  |                                  | 25. FUNERAL DIRECTOR<br><b>HENRY SANDER &amp; SONS, INC.</b>  |  | ADDRESS<br><b>Baltimore Md.</b>  |   |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 21 1950</b>   |                                  | REGISTRAR'S SIGNATURE<br><b>Wilmington Williams, M.D.</b>   |  | 25. FUNERAL DIRECTOR ADDRESS<br><b>Henry A. Sander</b>                               |   |

Adenocarcinoma of the adrenal gland. Letter in document  
file 50-5514 - 7/6/50

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5515  
Registered No.

|   |                                    |  |  |
|---|------------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>JAMES H. LEE</b>  |                                    | 2. DATE OF DEATH<br><b>June 19, 1950</b>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION<br><b>University Hospital</b> |                                    | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>4-02</b>                   |  |
| D. STREET ADDRESS (If rural, give location)<br><b>238 Pearl Street</b>  |                                    | 5. LENGTH OF STAY IN BALTIMORE<br>Yrs. _____<br>Mos. _____<br>Days _____   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Colored</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widower</b>  | 8. DATE OF BIRTH<br><b>Nov, 1892</b> <b>57</b> <b>59</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>                                 |                                    | 9. AGE (In years last birthday)<br><b>57</b> <b>59</b><br>If Under 1 Year: Months: Days<br>If Under 24 Hours: Hours: Min.      |  |
| 10B. KIND OF BUSINESS OR INDUSTRY   |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  |
| 13. FATHER'S NAME<br><b>James Lee</b>   |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><b>U S. A.</b>   |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Mary Maitland</b>  |                                    | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                       |  |
| 16. SOCIAL SECURITY NO.   |                                    | 17. INFORMANT ADDRESS<br><b>M's Fannie Saunders 238 Pearl St.</b>  |  |

|  |  |                                  |
|--|--|----------------------------------|
| 18. <b>443 X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Hypertensive cardiovascular disease</b><br>DUE TO |  | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO   |  |                                  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>Obesity</b>  |  |                                  |

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 19A. DATE OF OPERATION   |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that I took charge of the remains described above, held an <u>Inspection &amp; Inquiry</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |  |  |  |   |  |
| 23A. SIGNATURE<br><i>Stanley H. Dunsicker</i> M.D.   |  | 23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/> |  | 23C. DATE SIGNED<br><b>June 20, 1950</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>6-22-50</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Mt Zion Cem.</b>                           |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore CO., Md.</b>   |  | 24E. FUNERAL DIRECTOR ADDRESS<br><b>78 W. Biddle St</b>  |  |   |  |

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 21 1950</b> |  | REGISTRAR'S SIGNATURE<br><i>Wm. H. Williams</i> |  | 25. FUNERAL DIRECTOR ADDRESS<br><b>78 W. Biddle St</b> |  |
| VS 151   |  | <b>98899</b>                                    |  | <b>93D</b>   |  |

MEDICAL CERTIFICATION





M-241  
50 5516McKelvey  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5516  
Registered No.

BIRTH NO.

|   |                                  |   |   |  |   |
|---|----------------------------------|---|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Marshall H. Mc Kelvey</i>   |                                  |   | 2. DATE OF DEATH <i>June 19, 1950</i> <i>105 AM</i>   |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>2817 Overland Ave</i>                                    |                                  |   | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <i>Ind</i> B. COUNTY <i>Balto</i> |  |   |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION   |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore</i> <i>27-02</i>                       |  |   |
| 6. Length of stay in Baltimore <i>Life</i>  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><i>2817 Overland Ave</i>   |  |   |
| 7. SEX<br><i>Male</i>   | 8. COLOR OR RACE<br><i>White</i> | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Married</i> | 10. DATE OF BIRTH<br><i>Oct 10, 1894</i>  | 11. AGE (In years; last birthday)<br><i>55</i> | 12. Under 1 Year<br>Months: Days: Hours: Min. |
| 13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Salesman</i> |                                  |   | 14. KIND OF BUSINESS OR INDUSTRY<br><i>Cake Business</i>  |  |   |
| 15. BIRTHPLACE (State or foreign country)<br><i>Cockeysville, Md.</i>   |                                  |   | 16. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>   |  |   |
| 17. FATHER'S NAME<br><i>John Mc Kelvey</i>  |                                  |   | 18. MOTHER'S MAIDEN NAME<br><i>Lida Jones</i>   |  |   |
| 19. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)   |                                  |   | 20. SOCIAL SECURITY NO.   |  |   |
| 21. INFORMANT<br><i>Walter McKelvey</i>   |                                  |   | 22. ADDRESS<br><i>2817 Overland Ave</i>   |  |   |

|   |   |
|---|---|
| 23. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Coronary thrombosis</i> | 24. INTERVAL BETWEEN ONSET AND DEATH<br><i>Sudden</i> |
| 25. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><i>Coronary sclerosis</i>   | 26. 5 years   |
| 27. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><i>Chronic Myocarditis 3rd °</i><br><i>Aneurysm; Amputated left leg (Phlebotomy)</i>                       | 28. 8 years   |

|   |   |   |
|---|---|---|
| 29. DATE OF OPERATION                               | 30. MAJOR FINDINGS OF OPERATION   | 31. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 32. 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)      | 33. 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 34. 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)        |
| 35. 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 36. 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 37. 21F. HOW DID INJURY OCCUR?  |

38. I hereby certify that I attended the deceased from *April 15*, 19*50*, to *June 19*, 19*50*, that I last saw the deceased alive on *June 17*, 19*50*, and that death occurred at *1 A* m., from the causes and on the date stated above.

39. 22A. SIGNATURE *H. V. Harbold* 22B. ADDRESS *4706 Harford Road* 22C. DATE SIGNED *June 19, 1950*

23A. BURIAL, CREMATION, REMOVAL (Specify) *Burial* 23B. DATE *June 22/50* 23C. NAME OF CEMETERY OR CREMATORY *Resurrection Cemetery* 23D. LOCATION (City, town, or county) (State) *Cockeysville, Md.*

24. DATE RECEIVED BY LOCAL REGISTRAR 25. REGISTRAR'S SIGNATURE *William W. Williams* 26. FUNERAL DIRECTOR *Loring Byers* 27. ADDRESS *5005 Elkridge*

VS 150  
UN 21 1950

278 XV

93)

Harbold.

4706 Harford Rd.

425  
50 5517BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHX 50 5517  
Registered No.

BIRTH NO.

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Peter Olson</b>   |                                  | 2. DATE OF DEATH<br><b>June 20, 1950</b>   |  |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>  |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>D.C.</b><br>B. COUNTY <b>V-48</b> |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>INSTITUTION <b>U. S. Marine Hospital</b><br><b>Wyman Park Drive &amp; 31st Street</b> |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Washington</b>                                      |  |
| C. Length of stay in Baltimore <b>4 days</b><br>Yrs. Mos. Days  |                                  | D. STREET ADDRESS (If rural, give location)<br><b>1300 Main Ave., SW</b>   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>  | 8. DATE OF BIRTH<br><b>3/26/94</b>           |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Captain</b>   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Seafarer</b>   | 9. AGE (In years last birthday)<br><b>56</b> |
| 11. BIRTHPLACE (State or foreign country)<br><b>Sweden</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>?</b>   |  |
| 13. FATHER'S NAME<br><b>Person Olson</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>?</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>578-09-4285</b>  |  |
| 17. INFORMANT<br><b>Records- U.S. Marine Hospital</b>   |                                  | ADDRESS  |  |

18. **420.1** CAUSE OF DEATH  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
(A) **Arteriosclerosis, coronary with occlusion and myocardial infarction, pulmonary edema and hydrothorax, bilateral**  
DUE TO

INTERVAL BETWEEN ONSET AND DEATH

**3 days**

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 19A. DATE OF OPERATION <b>✓</b>   |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) MINUTE OF INJURY  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>June 16, 1950</b> , to <b>June 20, 1950</b> that I last saw the deceased alive on <b>June 20, 1950</b> and that death occurred at <b>7:25 pm.</b> from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE<br><b>John L. Wilson, Medical Director</b>   |  | 23B. ADDRESS<br><b>M. O. U.S. Marine Hospital, Balto., Md.</b>  |  | 23C. DATE SIGNED<br><b>6/20/50</b>  |  |

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> |  | 24B. DATE<br><b>6/24/50</b>                               |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill, Wash. D.C.</b> |  | 24D. LOCATION (City, town, or county) (State)<br><b>Washington D.C.</b> |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 21 1950</b>     |  | REGISTRAR'S SIGNATURE<br><b>Livingston Williams, M.D.</b> |  | 25. FUNERAL DIRECTOR<br><b>W. S. Frank, Inc. 2901 5th St NW</b>     |  | ADDRESS<br><b>Wash D.C.</b>   |  |

130 51

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CERTIFICATE OF DEATH

1910



500  
50 5518

50 5518

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

CHARLOTTE M. BOWEN

2. DATE  
OF  
DEATH

June 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

103 W. 39th St.

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
single

8. DATE OF BIRTH

Aug. 21, 1884

9. AGE (in years  
last birthday)

65 66

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)  
never employed10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Jacob T. Bowen

14. MOTHER'S MAIDEN NAME

Sarah Cox

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.17. INFORMANT ADDRESS  
Mrs. Pinkney L. Sothoron 103 W. 39th St

18. 204.2

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) .....  
DUE TO

Leukemia, monocytic

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) .....  
DUE TO

11

(C) .....

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 4, 1950 to June 21, 1950 that I last saw the  
deceased alive on June 1, 1950 and that death occurred at 6:00 a.m. from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

6/22/50

24C. NAME OF CEMETERY OR CREMATORY

Greenmount Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUN 21 1950

VS 150

74a





240  
50 5519BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5519  
Registered No.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| BIRTH NO.  |  | FREDERICK WILLIAM JOECKEL   |  | 2. DATE OF DEATH<br>June 21, 1950   |  |
| 1. NAME OF DECEASED<br>(Type or Print)   |  |   |  | 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>23rd & St. Paul Sts.<br>Beck's Clinic |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE<br>Maryland   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 28-04 |  |
| C. Length of stay in Baltimore<br>life   |  | D. STREET ADDRESS (If rural, give location)<br>4618 Coleherne Road--  |  | 8. DATE OF BIRTH<br>July 4, 1881  |  |
| 5. SEX<br>Male   |  | 6. COLOR OR RACE<br>White   |  | 9. AGE (In years last birthday)<br>68   |  |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>married                       |  | 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Chief Fire Dept. |  | 10B. KIND OF BUSINESS OR INDUSTRY<br>Balto. City  |  |
| 13. FATHER'S NAME<br>Conrad E. Joeckel   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br>no   |  | 16. SOCIAL SECURITY NO.<br>no   |  |
| 17. INFORMANT<br>Mrs. Mary M. Joeckel  |  | ADDRESS<br>4618 Coleherne Rd.   |  | 12. CITIZEN OF WHAT COUNTRY?  |  |

|   |  |                                  |
|---|--|----------------------------------|
| 18. 157X<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br>(A) Carcinoma of the head of the pancreas<br>with<br>(B) Metastases to the liver<br>(C) DUE TO |  | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |                                  |

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 19A. DATE OF OPERATION   |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                    |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED<br>m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |  |  |  |   |  |
| 23A. SIGNATURE<br>R. S. Fisher   |  | 23B. CHIEF MEDICAL EXAMINER.....<br>M.D. ASSISTANT MEDICAL INVESTIGATOR                                      |  | 23C. DATE SIGNED<br>June 21, 1950   |  |

|   |  |                                      |  |  |  |  |  |
|---|--|--------------------------------------|--|--|--|--|--|
| 24A. BURIAL, CREMA- TION, REMOVAL (Specify)<br>Burial |  | 24B. DATE<br>6/24/50                 |  | 24C. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cem. |  | 24D. LOCATION (City, town, or county) (State)<br>Pikesville, Md. |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br>JUN 21 1950       |  | REGISTRAR'S SIGNATURE<br>[Signature] |  | 25. FUNERAL DIRECTOR<br>Wm. J. Pickens & Son           |  | ADDRESS<br>[Address]   |  |

60098 469



STATE OF NEW YORK  
CERTIFICATE OF DEATH

|                        |  |                        |  |                       |  |
|------------------------|--|------------------------|--|-----------------------|--|
| Name of Deceased       |  | Sex                    |  | Age                   |  |
| Date of Death          |  | Place of Death         |  | Cause of Death        |  |
| Occupation             |  | Residence              |  | Manner of Death       |  |
| Signature of Physician |  | Signature of Registrar |  | Signature of Coroner  |  |
| Date of Certificate    |  | Place of Certificate   |  | Signature of Deceased |  |

*Wm. J. ...*

24

REA-138464

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

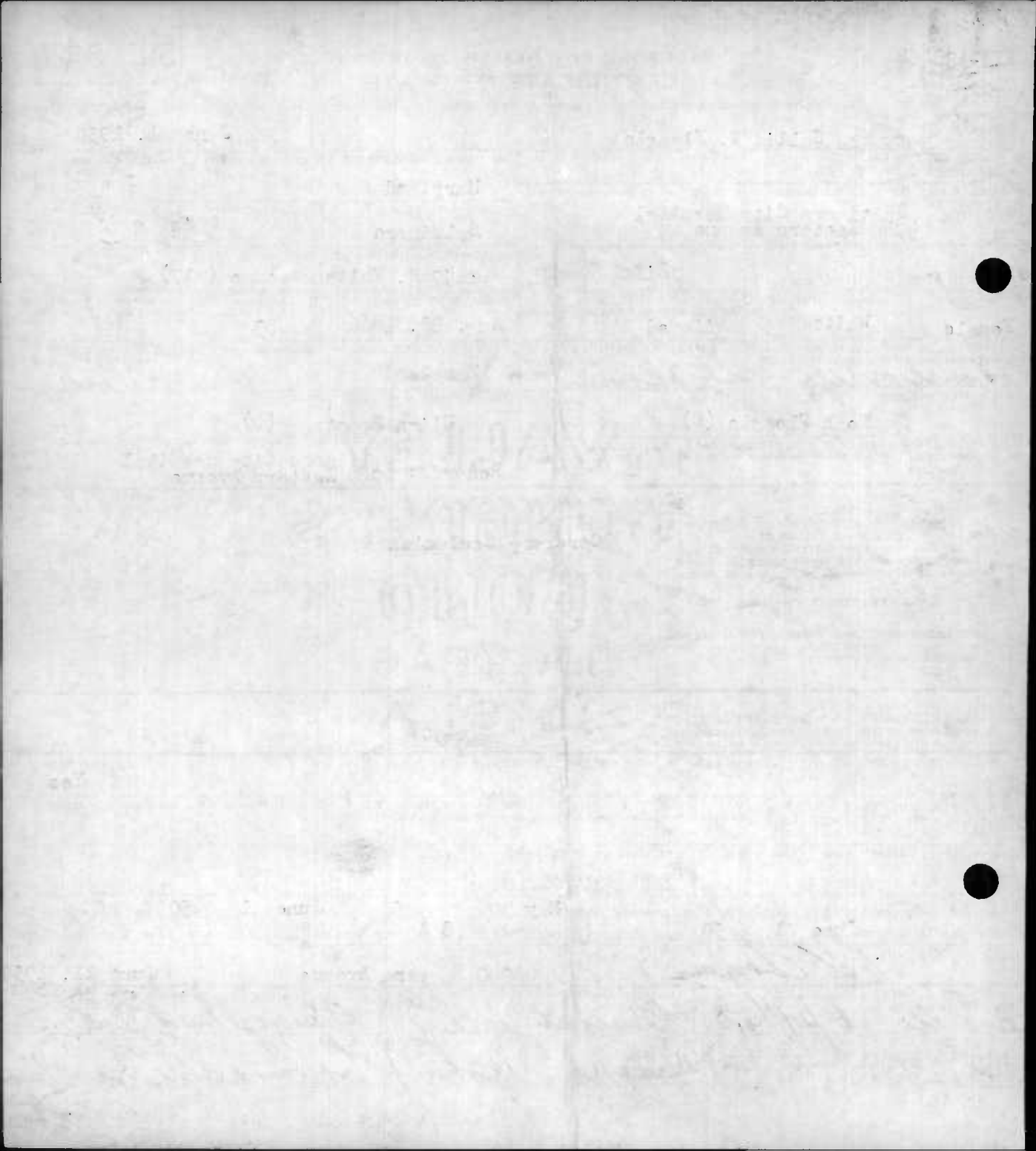
50 5520

Registered No.

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Sallie A. Fleagle</b>   |                                  | 2. DATE OF DEATH<br><b>June 21, 1950</b>   |  |
| 3. PLACE OF DEATH:<br>a. Baltimore City, Maryland  |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY |  |
| b. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>Baltimore City Hospital</b><br><b>4940 Eastern Avenue</b> |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>                               |  |
| c. Length of stay in Baltimore <b>Life</b>   |                                  | d. STREET ADDRESS (If rural, give location)<br><b>2259 N. Fulton Avenue (17)</b>   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b>  | 8. DATE OF BIRTH<br><b>Aug. 22, 1866</b>     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House Wife</b>                                     |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>at Home</b>  | 9. AGE (In years last birthday)<br><b>83</b> |
| 13. FATHER'S NAME<br><b>Noah Fleagle (D)</b>   |                                  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>-</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 16. SOCIAL SECURITY NO.<br><b>-</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Eliza Koontz (D)</b>  |  |
| 17. INFORMANT<br><b>Baltimore City Hospital</b>  |                                  | ADDRESS<br><b>Records: 4940 Eastern Avenue</b>   |  |

|  |                |                                  |
|--|----------------|----------------------------------|
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Coronary Occlusion</b> | CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B)<br>(C)   |                |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                |                                  |

|   |   |  |   |  |  |
|---|---|--|---|--|--|
| 19A. DATE OF OPERATION<br><b>2</b>  |   | 19B. MAJOR FINDINGS OF OPERATION   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> No <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDER- LYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |  |  |
| 22. I hereby certify that I attended the deceased from <b>May 30</b> 1950, to <b>June 21</b> , 1950, that I last saw the deceased alive on <b>June 21</b> , 1950, and that death occurred at <b>8 A</b> m., from the causes and on the date stated above. |   |  |   |  |  |
| 23A. SIGNATURE<br><b>H. Boyer</b>   |   | 23B. ADDRESS<br>M. D. <b>4940 Eastern Avenue</b>                         |   | 23C. DATE SIGNED<br><b>June 21, 1950</b>                                 |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 24B. DATE<br><b>6/24/50</b>   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Pleasant Valley</b>             | 24D. LOCATION (City, town, or county) (State)<br><b>Buzzsallburg Ind.</b> |  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 22 1950</b>  |   | REGISTRAR'S SIGNATURE<br><b>Wilmington Williams, M.D.</b>                |   | 25. FUNERAL DIRECTOR<br><b>John J. Brown &amp; Son</b>                   |  |
|   |   |  |   | ADDRESS<br><b>94a St.</b>  |  |



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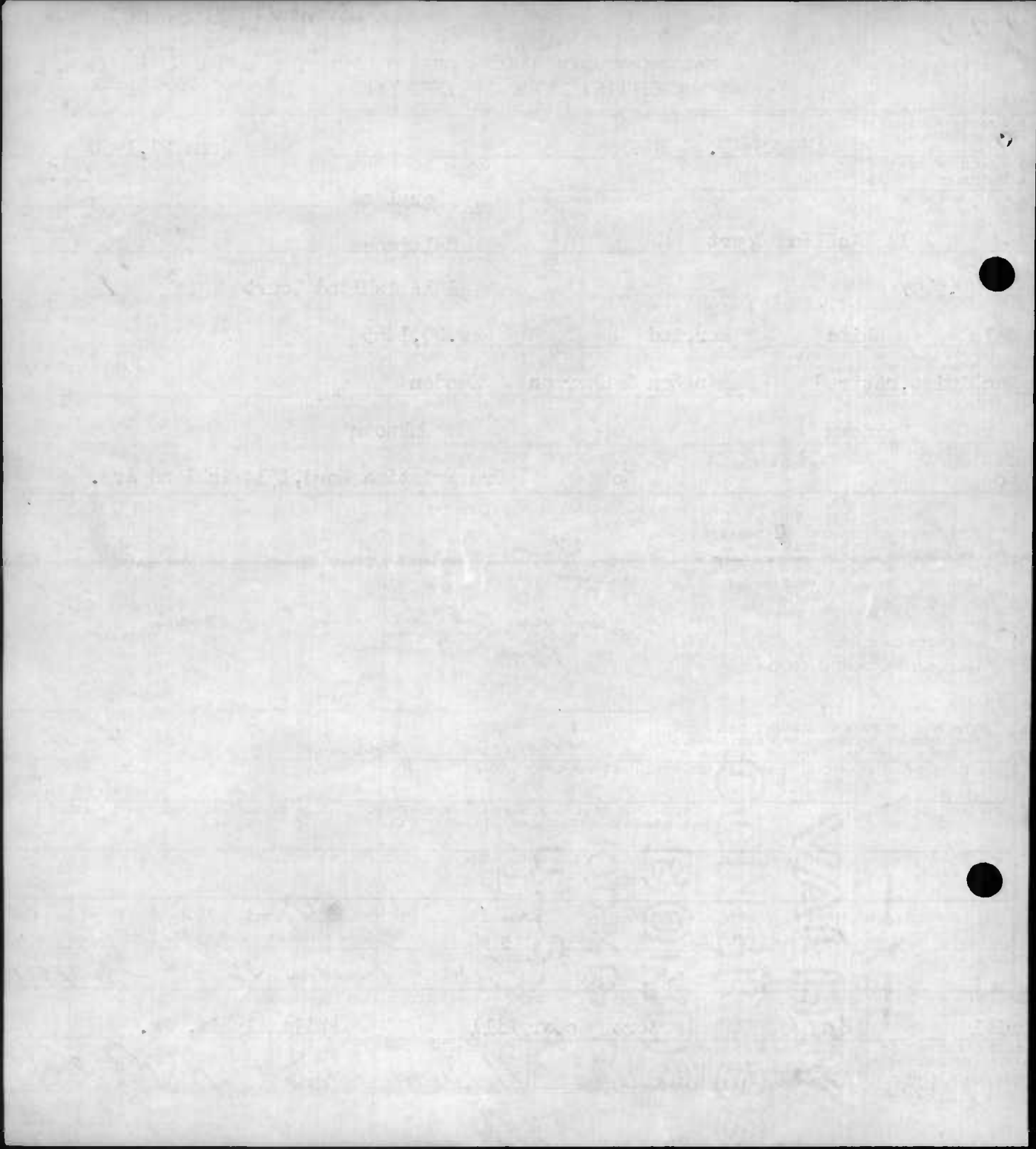
5521

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5521

Registered No.

|   |                                  |   |   |  |                                  |
|---|----------------------------------|---|---|--|----------------------------------|
| BIRTH NO.   |                                  |   | 2. DATE OF DEATH <b>June 21, 1950</b>   |  |                                  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>ANDERS M. NORD</b>  |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>Baltimore</b> |  |                                  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>  |  |                                  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>1014 Ashland Court</b>  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>1014 Ashland Court</b>  |  |                                  |
| C. Length of stay in Baltimore<br>Yrs.<br>Mos.<br>Days  |                                  |   | 5. DATE OF BIRTH<br><b>Nov. 20, 1865</b>  |  |                                  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>   | 9. AGE (In years last birthday)<br><b>84</b>  | If Under 1 Year<br>Months: Days  | If Under 24 Hours<br>Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Machinist, retired</b>  |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Remington &amp; Sherman</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Sweden</b>               |                                  |
| 13. FATHER'S NAME<br><b>Unknown</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>No</b>  |   | 17. INFORMANT ADDRESS<br><b>Mrs Kristina Nord, 1014 Ashland Ave.</b>     |                                  |
| 18. <b>442X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Chemia.</b><br>DUE TO<br><b>Arterio-sclerotic - Cardio-vascular</b><br><b>Renal Disease</b><br><b>Angustic failure</b> |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 weeks.</b><br><b>?</b><br><b>4 mos.</b>  |  |                                  |
| 19A. DATE OF OPERATION<br><b>0</b>  |                                  |   | 19B. MAJOR FINDINGS OF OPERATION  |  |                                  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                                       |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |                                  | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |                                  |
| 22. I hereby certify that I attended the deceased from <b>Jan 1</b> , 19 <b>50</b> , to <b>20 June</b> , 19 <b>50</b> that I last saw the deceased alive on <b>19 June</b> , 19 <b>50</b> and that death occurred at <b>m.</b> , from the causes and on the date stated above.  |                                  |   |   |  |                                  |
| 23A. SIGNATURE<br><b>Samuel Schiefer</b>  |                                  | 23B. ADDRESS<br><b>714 E. Preston St</b>  |   | 23C. DATE SIGNED<br><b>21 June 1950</b>                                  |                                  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 24B. DATE<br><b>6/23/50</b>   |   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>North Cedar Hill</b>            |                                  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Philadelphia, Pa.</b>   |                                  | 24E. FUNERAL DIRECTOR'S ADDRESS<br><b>William 1217 S Paul</b>   |   |  |                                  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 22 1950</b>  |                                  | REGISTRAR'S SIGNATURE<br><b>Wilmington Williams</b>   |   | 25. FUNERAL DIRECTOR'S ADDRESS<br><b>William 1217 S Paul</b>             |                                  |



530  
50-5522

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50-5522

|   |                                  |   |                                      |
|---|----------------------------------|---|--------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Mr. Merle B. Smith</b>  |                                  | 2. DATE OF DEATH<br><b>6.20.1950</b>  |                                      |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>Doctors Hospital</b>   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY |                                      |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Doctor's Hospital</b>  |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 27-08 B</b>                    |                                      |
| D. STREET ADDRESS (If rural, give location)<br><b>810 Cedarcraft Rd. 12</b>   |                                  | 5. LENGTH OF STAY IN BALTIMORE <b>46 years</b>  |                                      |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>married</b>   | 8. DATE OF BIRTH<br><b>12.3.1885</b> |
| 9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Hotel clerk</b>  |                                  | 9B. AGE (In years last birthday) <b>64</b>  |                                      |
| 10A. KIND OF BUSINESS OR INDUSTRY<br><b>Hotel Baltimore</b>   |                                  | 11. BIRTHPLACE (State or foreign country)<br><b>South Bend Indiana</b>  |                                      |
| 13. FATHER'S NAME<br><b>Eugene Smith</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                      |
| 14. MOTHER'S MAIDEN NAME<br><b>Madelle Bulla</b>  |                                  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)<br><b>No</b>                             |                                      |
| 16. SOCIAL SECURITY NO.   |                                  | 17. INFORMANT<br><b>Eugene Smith, 810 Cedarcraft Rd.</b>  |                                      |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Chronic Myocarditis</b>  |                                  | INTERVAL BETWEEN ONSET AND DEATH  |                                      |
| DUE TO (A) <b>Chronic Myocarditis</b>   |                                  |   |                                      |
| DUE TO (B) <b>Arteriosclerotic Cardiovascular Disease</b>   |                                  |   |                                      |
| DUE TO (C)  |                                  |   |                                      |
| 19A. DATE OF OPERATION <b>0</b>   |                                  | 19B. MAJOR FINDINGS OF OPERATION  |                                      |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |                                      |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                    |                                      |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                                  |   |                                      |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                   |                                      |
| 21F. HOW DID INJURY OCCUR?  |                                  |   |                                      |
| 22. I hereby certify that I attended the deceased from <b>May 3</b> 19 <b>48</b> to <b>June 20</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>June 20</b> , 19 <b>50</b> , and that death occurred at <b>5:40 p.m.</b> , from the causes and on the date stated above. |                                  |   |                                      |
| 23A. SIGNATURE<br><b>Harold B. Wolf</b>   |                                  | 23B. ADDRESS<br><b>1331 North Ave</b>   |                                      |
| 23C. DATE SIGNED<br><b>6-21-50</b>  |                                  |   |                                      |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 24B. DATE<br><b>6/23/50</b>   |                                      |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>Landon Park</b>  |                                  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Md</b>  |                                      |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 22 1950</b>  |                                  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b>   |                                      |
| FUNERAL DIRECTOR<br><b>William C. Kent</b>  |                                  | ADDRESS<br><b>1217 N. Paul St</b>   |                                      |

26687

937

CERTIFICATE OF DEATH

No. 10-100

The undersigned, a duly qualified and licensed physician, do hereby certify that on the 10th day of 1901, at the residence of the deceased, I attended the body of a person known to me as

John Doe

who died of

Heart Disease

at the age of 45 years.

Witness my hand and seal this 10th day of 1901.

Dr. J. H. Doe

Physician

Subscribed and sworn to before me this 10th day of 1901.

J. H. Doe

Notary Public



243  
5523

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5523

|  |                              |   |                                |
|--|------------------------------|---|--------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>HYMAN SCHUCALTER</b>   |                              | 2. DATE OF DEATH<br><b>June 21, 1950</b>  |                                |
| 3. PLACE OF DEATH:<br>a. <b>Baltimore City, Maryland</b>   |                              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY |                                |
| b. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>West Baltimore General Hospital</b> |                              | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 15-03</b>                      |                                |
| d. LENGTH OF STAY IN BALTIMORE<br><b>47</b> Yrs. Mos. Days   |                              | d. STREET ADDRESS (If rural, give location)<br><b>Garage Rear of 1822 Ruxton Ave.</b>                                       |                                |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Single</b>  | 8. DATE OF BIRTH<br><b>6-2</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>                  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Novelty Store</b>   |                                |
| 11. BIRTHPLACE (State or foreign country)<br><b>Russia</b>   |                              | 12. CITIZEN OF WHAT COUNTRY?  |                                |
| 13. FATHER'S NAME<br><b>Joseph</b>   |                              | 14. MOTHER'S MAIDEN NAME<br><b>Rachael</b>  |                                |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                        |                              | 16. SOCIAL SECURITY NO.   |                                |
| 17. INFORMANT<br><b>Jennie Rudman</b>  |                              | ADDRESS<br><b>1636 Ruxton Ave</b>   |                                |

18. **470.1**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Coronary artery disease**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21e. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR?  |  |

22. I certify that I took charge of the remains described above, held an **Insp. & Inq.** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 23a. SIGNATURE<br><b>[Signature]</b>                       |  | 23b. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> M.D. |  | 23c. DATE SIGNED<br><b>June 21, 1950</b>              |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> |  | 24b. DATE<br><b>6-22-50</b>  |  | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Rosedale</b> |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 22 1950</b>     |  | REGISTRAR'S SIGNATURE<br><b>Wilmington Williams, M.D.</b>  |  | 25. FUNERAL DIRECTOR<br><b>Jack Lewis Inc</b>         |  |
|  |  |  |  | ADDRESS<br><b>2100 Eutan Pl</b>                       |  |

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15661  
94a ✓

MEDICAL CERTIFICATION

UNITED STATES DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

21

DEATH

655  
50 5524BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5524  
Registered No.

|   |                                  |   |                  |  |   |
|---|----------------------------------|---|------------------|--|---|
| BIRTH NO.   |                                  | 1. NAME OF DECEASED<br>(Type or Print) <b>SAMUEL SHERMAN</b>  |                  | 2. DATE OF DEATH <b>June 21-1950</b>                                     |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md</b> B. COUNTY |                  |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>2516 Quantico Ave</b>   |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 15-13</b>                |                  |  |   |
| C. Length of stay in Baltimore<br><b>Life</b>   |                                  | D. STREET ADDRESS (If rural, give location)<br><b>2516 Quantico Ave</b>   |                  |  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>married</b>   | 8. DATE OF BIRTH | 9. AGE (In years last birthday)<br><b>57</b>                             | 10. Under 1 Year Months Days<br>11. Under 24 Hours Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during the most of working life, even if retired)<br><b>Postal Clerk</b>  |                                  | 10B. KIND OF BUSINESS OR INDUSTRY   |                  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore Md</b>         |   |
| 12. CITIZEN OF WHAT COUNTRY?  |                                  | 13. FATHER'S NAME<br><b>Isaac Morovitz</b>  |                  | 14. MOTHER'S MAIDEN NAME<br><b>Rena</b>                                  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES (If yes, give war or dates of service)<br><b>Yes, no or unknown</b>   |                                  | 16. SOCIAL SECURITY NO.   |                  | 17. INFORMANT<br><b>Bella Sherman</b>                                    |   |
| 18. <b>420.1</b>  |                                  | CAUSE OF DEATH  |                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 day</b>                         |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   |                                  | (A) <b>Coronary Thrombosis</b>  |                  |  |   |
| DUE TO  |                                  | (B)   |                  |  |   |
| ANTECEDENT CAUSES   |                                  | (C)   |                  |  |   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |                                  | DUE TO  |                  |  |   |
| II  |                                  | (C)   |                  |  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                                  |   |                  |  |   |
| 19A. DATE OF OPERATION  |                                  | 19B. MAJOR FINDINGS OF OPERATION  |                  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                             |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                  | 21E. INJURY OCCURRED<br>WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK             |                  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <b>June 19, 1950</b> , to <b>June 21, 1950</b> , that I last saw the deceased alive on <b>June 21, 1950</b> , and that death occurred at <b>1:20 p. m.</b> , from the causes and on the date stated above. |                                  |   |                  |  |   |
| 23A. SIGNATURE<br><b>Marshall Levin</b>   |                                  | 23B. ADDRESS<br><b>4518 Reisterstown Road</b>   |                  | 23C. DATE SIGNED<br><b>June 21/50</b>                                    |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 24B. DATE<br><b>6-23-50</b>   |                  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Rosedale</b>                    |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Md</b>  |                                  | 24E. DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 22 1950</b>   |                  | 24F. REGISTRAR'S SIGNATURE<br><b>Wilmington Williams, M.D.</b>           |   |
| 24G. FUNERAL DIRECTOR<br><b>Jack Lewis Inc</b>  |                                  | 24H. ADDRESS<br><b>2100 Eutaw Pl</b>  |                  | 24I. <b>26695</b>  |   |



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5525

Registered No. \_\_\_\_\_

5525

BIRTH NO.

|  |                                  |   |  |   |   |
|--|----------------------------------|---|--|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>William J. Freeburger</b>  |                                  |   | 2. DATE OF DEATH <b>June 20, 1950</b>  |   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>Baltimore</b>   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY _____ |   |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>919 E. Biddle St.</b> |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>10-01</b>                        |   |   |
| c. Length of stay in Baltimore<br>Yrs. _____<br>Mos. _____<br>Days _____   |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>919 E. Biddle St</b>   |   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widower</b> | 8. DATE OF BIRTH<br><b>Dec. 12, 1893</b>   | 9. AGE (In years: last birthday)<br><b>56</b> | If Under 1 Year: Months _____ Days _____<br>If Under 24 Hours: Hours _____ Min. _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Fire Fighter</b>                       |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>City</b>                  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |
| 13. FATHER'S NAME<br><b>Oliver A. Freeburger</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Madaline Franz</b>  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>No</b>                              | 17. INFORMANT ADDRESS<br><b>Elizabeth C. Beran, 2604 Robb St</b>   |   |   |

|  |  |  |  |
|--|--|--|--|
| 18. <b>331X1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | CAUSE OF DEATH<br><br>(A) <b>Cerebral Hemorrhage</b><br>DUE TO<br><br>(B) <b>Hypertension</b><br>DUE TO<br><br>(C) _____ |  | INTERVAL BETWEEN ONSET AND DEATH<br><br><b>Immediate</b><br><br><b>Months.</b> |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|   |   |  |  |   |  |
|---|---|--|--|---|--|
| 19A. DATE OF OPERATION <b>None</b>                |   | 19B. MAJOR FINDINGS OF OPERATION <b>None</b>                             |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)        | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) <b>None</b> | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |   |  |

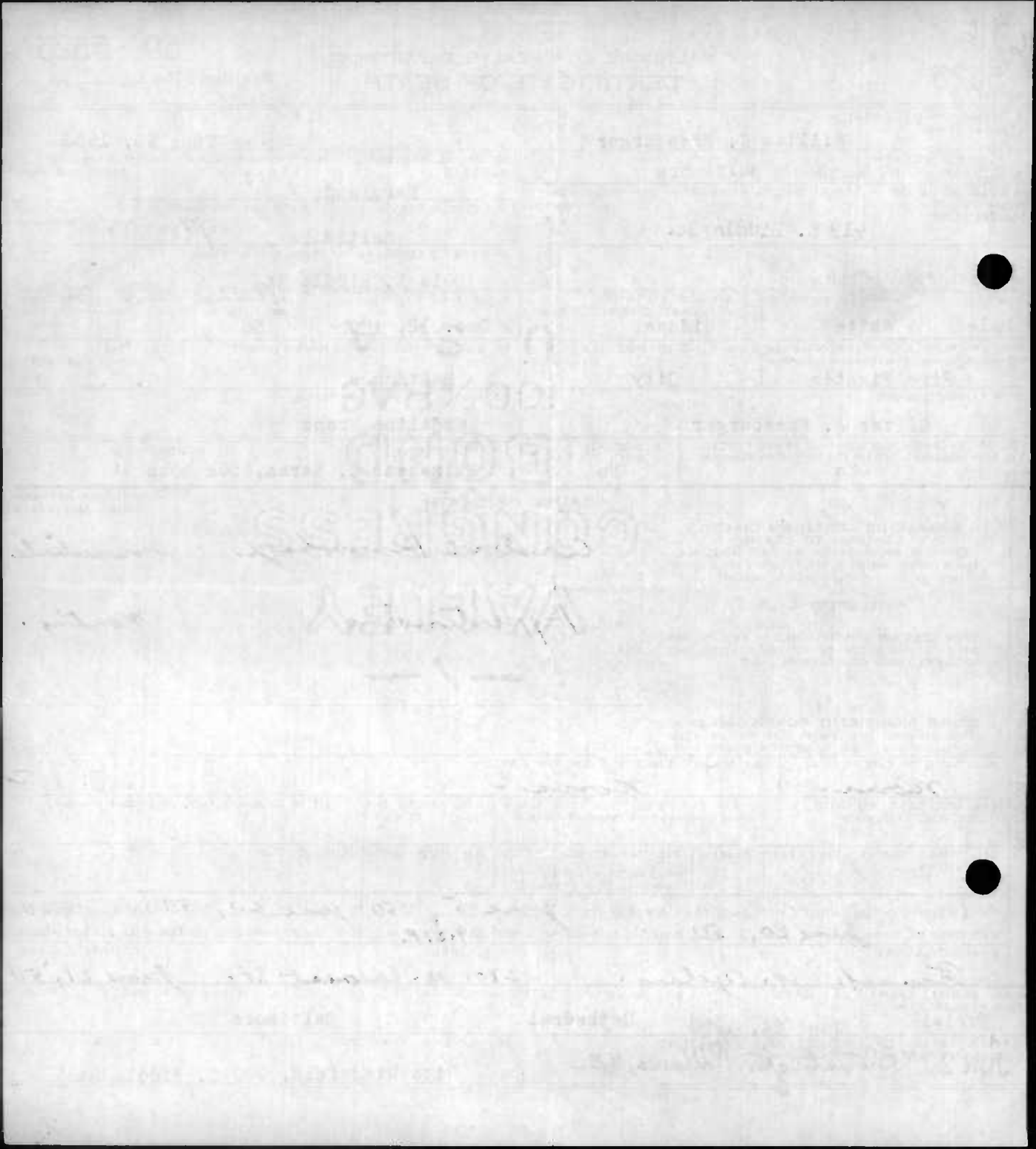
22. I hereby certify that I attended the deceased from June 5, 1950, to June 20, 1950, that I last saw the deceased alive on June 20, 1950, and that death occurred at 9:27 p.m., from the causes and on the date stated above.

|  |                                   |   |   |   |  |
|--|-----------------------------------|---|---|---|--|
| 23A. SIGNATURE<br><b>Frank M. Ochs</b>                     |                                   | 23B. ADDRESS<br><b>2701 N. Calvert St.</b>                |   | 23C. DATE SIGNED<br><b>June 21, 1950</b>                                |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24B. DATE<br><b>June 24, 1950</b> | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Cathedral</b>    | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore</b> |   |  |
| DATE RECEIVED BY LOCAL REGISTRY<br><b>JUN 22 1950</b>      |                                   | REGISTRAR'S SIGNATURE<br><b>Wilmington Williams, M.D.</b> |   | 25. FUNERAL DIRECTOR ADDRESS<br><b>Rita Wiedefeld, 900 E. Biddle St</b> |  |

60098

83a

MEDICAL CERTIFICATION



324  
50 5526BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5526

|   |                             |   |                             |   |   |
|---|-----------------------------|---|-----------------------------|---|---|
| BIRTH NO.   |                             | 1. NAME OF DECEASED<br>(Type or Print) JUNE MITCHELL  |                             | 2. DATE OF DEATH<br>June 19, 1950                 |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland<br>B. COUNTY |                             |   |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTE University Hospital |                             | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 4-02                          |                             |   |   |
| Length of stay in Baltimore 12 Yrs. Mos. Days   |                             | D. STREET ADDRESS (If rural, give location)<br>635 W. Mulberry Street   |                             |   |   |
| 5. SEX<br>Male  | 6. COLOR OR RACE<br>Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Widowed  | 8. DATE OF BIRTH<br>?? 1889 | 9. AGE (In years last birthday)<br>67             | 10. Under 1 Year<br>Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Landscape                          |                             | 10B. KIND OF BUSINESS OR INDUSTRY<br>odd jobs.  |                             | 11. BIRTHPLACE (State or foreign country)<br>N.C. |   |
| 12. CITIZEN OF WHAT COUNTRY?<br>W.S.A.  |                             | 13. FATHER'S NAME<br>Allen Mitchell   |                             | 14. MOTHER'S MAIDEN NAME<br>Elysa Williams        |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or date of service)<br>no none  |                             | 16. SOCIAL SECURITY NO.<br>?  |                             | 17. INFORMANT<br>Dick Hall - 635 W. Mulberry St.  |   |

|  |   |                                  |
|--|---|----------------------------------|
| 18. 490 X I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>Lobar pneumonia<br>DUE TO<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | CAUSE OF DEATH<br>(A) Lobar pneumonia<br>DUE TO<br>(B)<br>DUE TO<br>(C) | INTERVAL BETWEEN ONSET AND DEATH |
|--|---|----------------------------------|

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 19A. DATE OF OPERATION   |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |  |   |  |   |  |
| 23A. SIGNATURE<br>Earl K. Ryan   |  | 23B. CHIEF MEDICAL EXAMINER.....<br>M.D. MEDICAL INVESTIGATOR.....  |  | 23C. DATE SIGNED<br>6-19-50   |  |

|   |                      |  |  |
|---|----------------------|--|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)       | 24B. DATE<br>6/13/50 | 24C. NAME OF CEMETERY OR CREMATORY<br>Wilson N.C.  | 24D. LOCATION (City, town, or county) (State)<br>N. C. |
| DATE RECEIVED BY LOCAL REGISTRAR<br>JUN 22 1950 |                      | REGISTRAR'S SIGNATURE<br>Huntington Williams, M.D. |  |
| FUNERAL DIRECTOR<br>W. Halstead - 918 - 904 VV  |                      | ADDRESS<br>Leland Hill Ave 108                     |  |





651

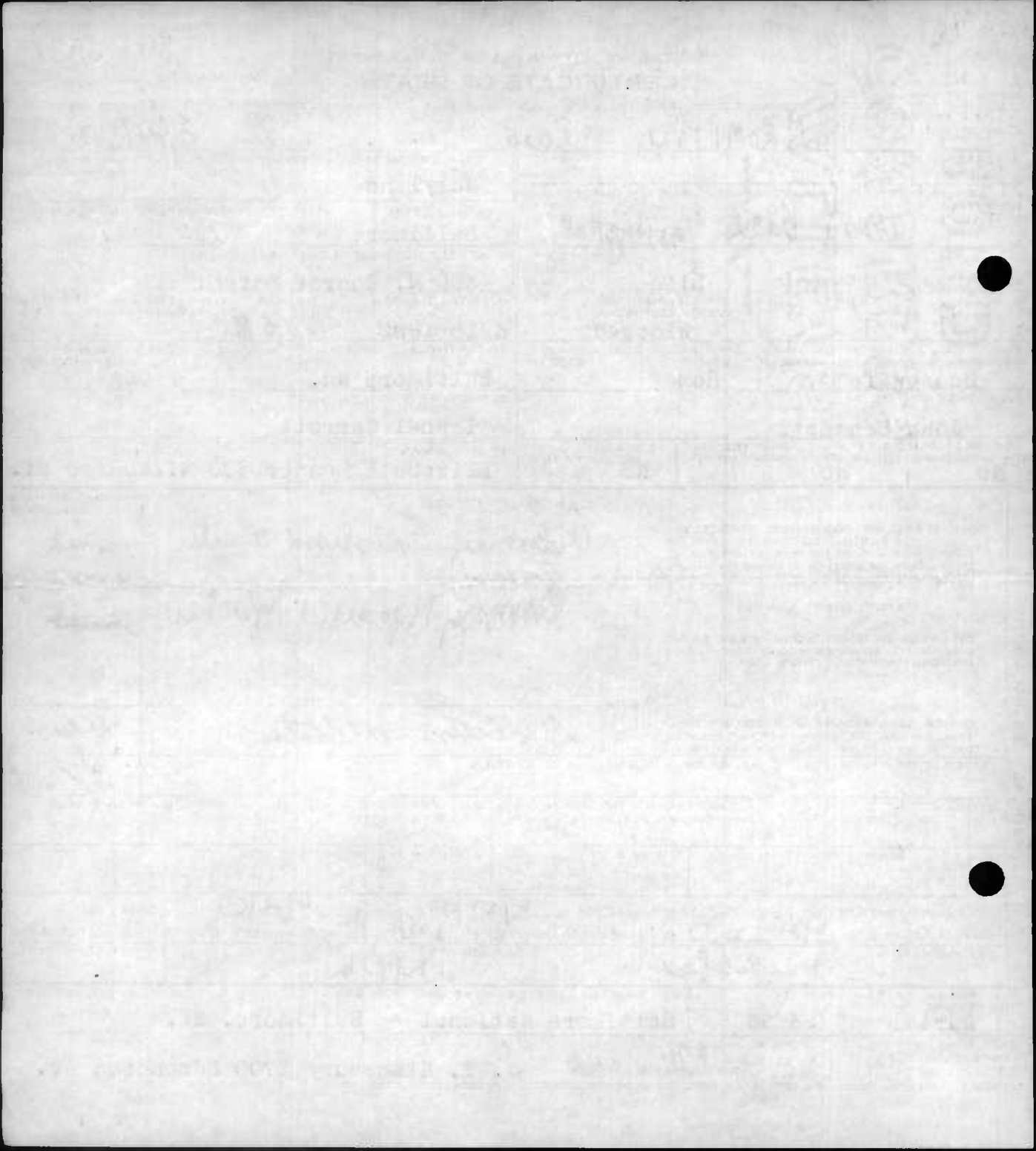
0 5527

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5527

Registered No.

|  |                           |  |  |  |   |
|--|---------------------------|--|--|--|---|
| BIRTH NO.  |                           | 1. NAME OF DECEASED<br>(Type or Print) <b>CROMPTON, ROSE A.</b>  |  | 2. DATE OF DEATH <b>6/21/50.</b>   |   |
| 3. PLACE OF DEATH:<br>a. Baltimore City, Maryland  |                           | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |  |  |   |
| b. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>West Baltimore Gen Hospital</b>  |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 20-01</b>                         |  |  |   |
| c. Length of stay in Baltimore <b>Life</b>   |                           | d. STREET ADDRESS (If rural, give location)<br><b>300 N. Monroe Street</b>   |  |  |   |
| 5. SEX <b>F</b>  | 6. COLOR OR RACE <b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b>  |  | 8. DATE OF BIRTH<br><b>6/18/1892</b>                                     | 9. AGE (In years last birthday) <b>58</b>   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                           | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore Md.</b>        |   |
| 13. FATHER'S NAME<br><b>John Schwartz</b>  |                           | 14. MOTHER'S MAIDEN NAME<br><b>Isabel Carroll</b>  |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>No</b>   |                           | 16. SOCIAL SECURITY NO.<br><b>No</b>   |  | 17. INFORMANT ADDRESS<br><b>Elixabeth Renner 300 N. Monroe St.</b>       |   |
| 18. <b>420.1</b>   |                           | CAUSE OF DEATH   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  |                           | (A) <b>Pulmonary Embolism, acute</b>   |  |  | <b>immed. approx 10 days</b>  |
| ANTECEDENT CAUSES  |                           | (B) <b>Myocardial infarction</b>   |  |  |   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE. (A) STATING THE UNDERLYING CONDITION LAST.   |                           | (C) <b>Diabetes mellitus</b>   |  |  | <b>4 yrs.</b>   |
| 19A. DATE OF OPERATION <b>2</b>  |                           | 19B. MAJOR FINDINGS OF OPERATION   |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |                           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                       |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   |                           | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                      |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <b>6/17/50</b> , 19 <b>50</b> , to <b>6/21/50</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>6/21</b> , 19 <b>50</b> , and that death occurred at <b>3:05 A.M.</b> , from the causes and on the date stated above. |                           |  |  |  |   |
| 23A. SIGNATURE<br><b>Joseph Shear</b>  |                           | 23B. ADDRESS<br><b>W.B.S.H.</b>  |  | 23C. DATE SIGNED   |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                           | 24B. DATE<br><b>6/23/50</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>          |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>   |                           | 25. FUNERAL DIRECTOR ADDRESS<br><b>J. T. Stansbury 2700 Edmondson Av.</b>  |  |  |   |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 22 1950</b>   |                           | REGISTRAR'S SIGNATURE<br><b>Wm. J. Williams, M.D.</b>  |  |  |   |



462

50 5528

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 5528

Registered No.

1. NAME OF DECEASED

(Type or Print)

JAMES PILARSKI

James Michael Pilarski

2. DATE OF DEATH

June 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

C. CITY OR TOWN

Baltimore

D. STREET ADDRESS (If rural, give location)

2822 Elliott Street

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

Baltimore City Hospital

C. Length of stay in Baltimore

Life

Yrs. Mos. Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Sept 1898

9. AGE (In years last birthday)

51

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Labor

10B. KIND OF BUSINESS OR INDUSTRY

Balto Copper Works

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Michael Pilarski

14. MOTHER'S MAIDEN NAME

Elizabeth Gulczynski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

Yes

World War 1

16. SOCIAL SECURITY NO.

212-10-1171

17. INFORMANT

Frances League

ADDRESS

2939 Fait Ave

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

420.1

CAUSE OF DEATH

CORONARY ARTERY DISEASE

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒

NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ NOT WHILE ☐ WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒

23C. DATE SIGNED

June 21, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

June 24, 1950

24C. NAME OF CEMETERY OR CREMATORY

Holy Cross Cemetery

24D. LOCATION (City, town, or county) (State)

German Hill Road Md.

DATE RECEIVED BY LOCAL REGISTRAR

JUN 22 1950

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

1800 E LOMBARD ST

VS 151

98831

94a

462

50 5528

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 5528

Registered No.

1. NAME OF DECEASED

(Type or Print)

JAMES PILARSKI

James Michael Pilarski

2. DATE OF DEATH

June 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

C. CITY OR TOWN

Baltimore

D. STREET ADDRESS (If rural, give location)

2822 Elliott Street

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

Baltimore City Hospital

C. Length of stay in Baltimore

Life

Yrs. Mos. Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Sept 1898

9. AGE (In years last birthday)

51

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Labor

10B. KIND OF BUSINESS OR INDUSTRY

Balto Copper Works

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Michael Pilarski

14. MOTHER'S MAIDEN NAME

Elizabeth Gulczynski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

Yes

World War 1

16. SOCIAL SECURITY NO.

212-10-1171

17. INFORMANT

Frances League

ADDRESS

2939 Fait Ave

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

420.1

CAUSE OF DEATH

CORONARY ARTERY DISEASE

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒

NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ NOT WHILE ☐ WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒

23C. DATE SIGNED

June 21, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

June 24, 1950

24C. NAME OF CEMETERY OR CREMATORY

Holy Cross Cemetery

24D. LOCATION (City, town, or county) (State)

German Hill Road Md.

DATE RECEIVED BY LOCAL REGISTRAR

JUN 22 1950

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

1800 E LOMBARD ST

VS 151

98831

94a

CERTIFICATE OF DEATH

Attest: \_\_\_\_\_

State of \_\_\_\_\_

County of \_\_\_\_\_

City of \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_ 19\_\_\_\_

I, \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

435

5529

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5529

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>CHARLES HAROLD FIELDING</b>     |                                  | 2. DATE OF DEATH<br><b>6-21-50</b>   |  |
| 3. PLACE OF DEATH:<br>a. <b>Baltimore City, Maryland</b>                  |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> |  |
| b. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>UNION MEMORIAL HOSPITAL</b> |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTIMORE 14-01</b>                                       |  |
| c. Length of stay in Baltimore<br><b>—</b>                                |                                  | d. STREET ADDRESS (If rural, give location)<br><b>709 W. North Ave.</b>  |  |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>  | 8. DATE OF BIRTH<br><b>Aug 3, 1886</b> |
| 9. AGE (In years last birthday)<br><b>63</b>                              |                                  | 10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>ELECT CONTRACTOR</b>                     |  |
| 10b. KIND OF BUSINESS OR INDUSTRY<br><b>SELF</b>                          |                                  | 11. BIRTHPLACE (State or foreign country)<br><b>Colorado</b>   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                |                                  | 13. FATHER'S NAME<br><b>Unknown</b>  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>                                |                                  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or <u>unknown</u> ) (If yes, give war or dates of service)                             |  |
| 16. SOCIAL SECURITY NO.   |                                  | 17. INFORMANT ADDRESS<br><b>WIFE - MRS. CHAS. FIELDING</b>   |  |

|   |  |  |
|---|--|--|
| 18. <b>491X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>(A) Bilateral Broncho pneumonia</b><br>DUE TO<br><b>(B) Hypostatic Pulmonary congestion</b><br>DUE TO<br><b>(C) Left Ventricular hypertrophy; Obesity</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>48 hrs.</b> |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |  |

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 19A. DATE OF OPERATION<br><b>2</b>  |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>June 21</b> , 19 <b>50</b> , to <b>June 21</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>6-21</b> , 19 <b>50</b> , and that death occurred at <b>1:25</b> m., from the causes and on the date stated above. |  |  |  |   |  |
| 23A. SIGNATURE<br><b>Richard R. Beach</b>   |  | 23B. ADDRESS<br><b>Union Memorial</b>  |  | 23C. DATE SIGNED<br><b>6/21/50</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>6/24/50</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Catharines</b>                             |  |
| 24D. LOCATION (City, town, or county)<br><b>Catharines</b>  |  | 24E. LOCATION (State)<br><b>MD</b>   |  | 25. FUNERAL DIRECTOR<br><b>Wm. McKim</b>  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 22 1950</b>  |  | REGISTRAR'S SIGNATURE<br><b>Wm. McKim</b>  |  | ADDRESS<br><b>1217 St Paul St</b>   |  |

156 Vg

95c

MEDICAL CERTIFICATION

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

Washington, D. C. 20535

DATE: 10/10/68

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]



2-524

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5530  
Registered No.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| BIRTH NO. 50 5530  |  | 1. NAME OF DECEASED<br>(Type or Print) <b>Walter R. Langley Jr.</b>   |  | 2. DATE OF DEATH <b>6-21-50</b>                                   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>Baltimore</b> |  |   |  |
| 5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br><b>1311 N. Eden St.</b> |  | 6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>  |  |   |  |
| 7. D. STREET ADDRESS (If rural, give location)<br><b>1311 N. Eden St.</b>  |  | 8. DATE OF BIRTH <b>Nov. 4, 1895</b>  |  |   |  |
| 9. SEX <b>Male</b>   |  | 10. COLOR OR RACE <b>Colored</b>  |  | 11. AGE (in years, months, days) <b>54 55</b>                     |  |
| 12. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)   |  | 13. BIRTHPLACE (State or foreign country) <b>Maryland</b>   |  | 14. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>                      |  |
| 15. FATHER'S NAME <b>Walter R. Langley</b>   |  | 16. MOTHER'S MAIDEN NAME <b>Carrie B. Keely</b>   |  |   |  |
| 17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)  |  | 18. SOCIAL SECURITY NO.   |  | 19. INFORMANT ADDRESS <b>Miss Myrtle Langley 1012 N. Eden St.</b> |  |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 18. 357 X<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   |  | CAUSE OF DEATH<br>(A) <b>Septicemia</b><br>DUE TO   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6/7/50</b>                                   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  | (B) <b>Hypostatic pneumonia and decubitus</b><br>DUE TO   |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  | (C) <b>Syngonmyelia</b>   |  | <b>March 1950</b>   |  |
| 19A. DATE OF OPERATION <b>0</b>  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>March 1950</b> , to <b>June 21, 1950</b> , that I last saw the deceased alive on <b>June 20, 1950</b> , and that death occurred at <b>12:50 A.M.</b> , from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE <b>Ralph J. Young</b>   |  | 23B. ADDRESS <b>1429 E. Monument St.</b>  |  | 23C. DATE SIGNED <b>6/21, 1950</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 24B. DATE <b>6-23-50</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>                          |  |
| 24D. LOCATION (City, town, or county) <b>A. A. Co., Md.</b>  |  | 24E. FUNERAL DIRECTOR <b>(Mrs) Frances A. Hemsley</b>   |  | 24F. ADDRESS <b>578 W. Biddle St.</b>   |  |
| DATE RECEIVED BY LOCAL REGISTRAR <b>JUN 22 1950</b>  |  | REGISTRAR'S SIGNATURE <b>Wm. Williams</b>   |  | 75081   |  |

MEDICAL CERTIFICATION

82

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

Washington, D. C. 20535

TO : DIRECTOR, FBI (100-371000)  
FROM : SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: 12/1/68

100-371000

100-100000

100-371000

100-100000

100-371000

100-100000

100-371000

100-100000

100-371000

100-100000

100-371000



UNITED STATES OF AMERICA  
DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

REPORT OF

DATE

BY

FILE NO.

CHARACTER OF CASE

SYNOPSIS

1

330

5532

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5532

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH M. STODA

2. DATE  
OF DEATH June 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

2232 Fleet Street

C. Length of stay in Baltimore 67 yrs.

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Married

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Oyster Shucker Ret.

10B. KIND OF BUSINESS OR INDUSTRY  
Oyster Packers

13. FATHER'S NAME

Martin Stoda

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknowns) (If yes, give war or dates of service)  
No16. SOCIAL SECURITY NO.  
212-10-8057

8. DATE OF BIRTH

September 4, 1878

9. AGE (in years last birthday)

71

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF  
WHAT COUNTRY?  
USA

14. MOTHER'S MAIDEN NAME

Mary -----

17. INFORMANT

ADDRESS

Mrs. Mary Stoda, 2232 Fleet Street

18. 581.0

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Acute Coronary Thrombosis 12 h.  
Arrhythmia of heart 58.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATHOTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/14/1944 to 6/21/1950, that I last saw the deceased alive on 6/19/1950, and that death occurred at 11:00 a. m., from the causes and on the date stated above.

23A. SIGNATURE

Charles Sadowski

M. D.

23B. ADDRESS

2579 Eastern Ave

23C. DATE SIGNED

6/17/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

6/24/50

24C. NAME OF CEMETERY OR CREMATORY

St. Stanislaus

24D. LOCATION (City, State and County)

Baltimore, Maryland

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

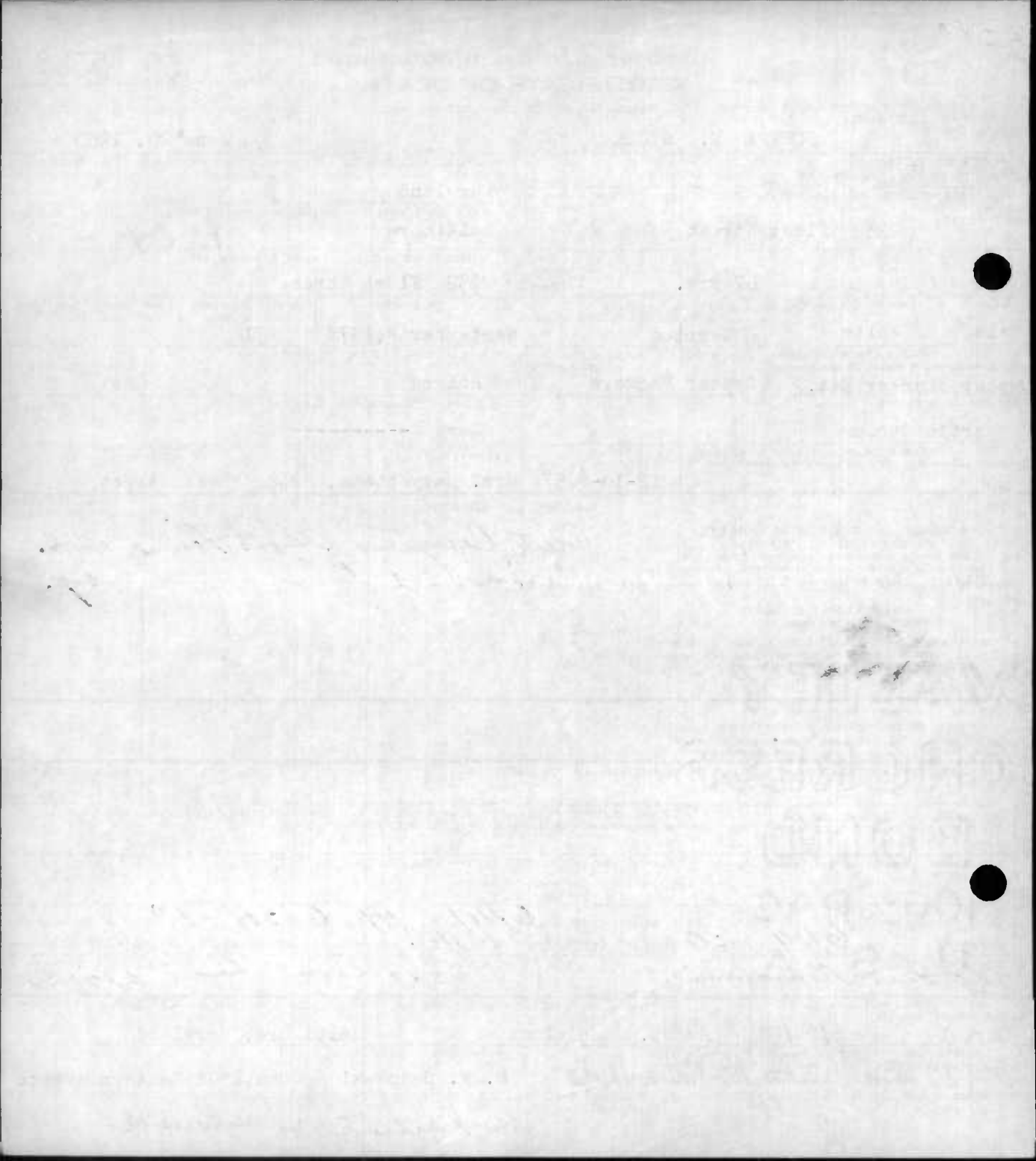
M. F. Sadowski &amp; Sons, 1808 Eastern Avenue

VS 150

496X1

Charles S. Sadowski, 24 B

MEDICAL CERTIFICATION





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5533  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>OLIVIA A. HYSON</b> (Alice Olivia Hyson)                                    |                                  | 2. DATE OF DEATH<br><b>6/21/50</b>  |   |
| 3. PLACE OF DEATH:<br>a. Baltimore City, Maryland   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> |   |
| b. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>So. Baltimore Gen. Hospital</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Point Pleasant 5200</b>                                      |   |
| c. Length of stay in Baltimore<br>Yrs. _____ Mos. _____ Days _____  |                                  | d. STREET ADDRESS (If rural, give location)<br><b>None</b>  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>   | 8. DATE OF BIRTH<br><b>Feb. 15, 1884</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>       |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>   | 9. AGE (In years last birthday) <b>66</b><br>If Under 1 Year: Months: _____ Days: _____<br>If Under 24 Hours: Hours: _____ Min: _____ |
| 13. FATHER'S NAME<br><b>John Everhart</b>   |                                  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b> |                                  | 12. CITIZEN OF WHAT COUNTRY?<br>_____   |   |
| 16. SOCIAL SECURITY NO.<br><b>None</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Alice Wells</b>  |   |
| 17. INFORMANT<br><b>Harry Hyson, Pt. Pleasant, Md.</b>  |                                  | ADDRESS<br>_____  |   |

|   |  |   |
|---|--|---|
| 18. <b>331X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | CAUSE OF DEATH<br>(A) <b>Cerebral hemorrhage</b><br>DUE TO<br>(B) <b>Cerebral arteriosclerosis</b><br>DUE TO<br>(C) <b>Diabetes mellitus</b> | INTERVAL BETWEEN ONSET AND DEATH<br>_____<br>_____<br>_____ |
|   | 19a. DATE OF OPERATION <b>0</b> 19b. MAJOR FINDINGS OF OPERATION<br>_____<br>_____   |   |
|   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |

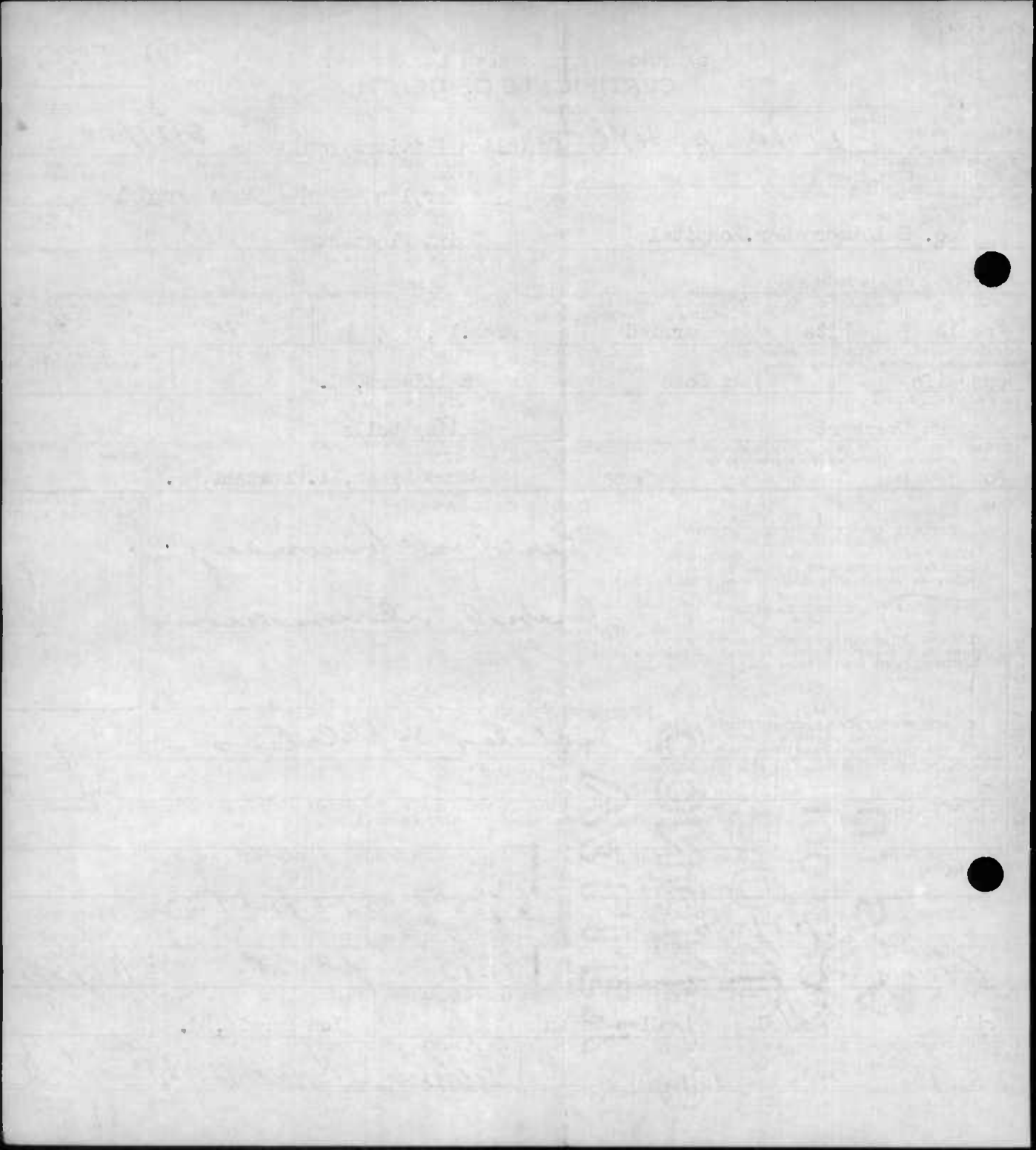
|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)<br>_____  |  | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br>_____        |  | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>_____ |  |
| 21d. TIME (Month) (Day) (Year) (Hour) (Minute)<br>INJURY<br>_____ m.   |  | 21e. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR?<br>_____   |  |
| 22. I hereby certify that I attended the deceased from <b>5/15/50</b> to <b>6/21/50</b> , that I last saw the deceased alive on <b>6/21/50</b> , and that death occurred at <b>9:00 p.m.</b> , from the causes and on the date stated above. |  |   |  |   |  |

|   |  |                                       |  |                                    |  |
|---|--|---------------------------------------|--|------------------------------------|--|
| 23a. SIGNATURE<br><b>Harry D. Yagurjian</b> M. D. |  | 23b. ADDRESS<br><b>1213 Light St.</b> |  | 23c. DATE SIGNED<br><b>6/21/50</b> |  |
|---|--|---------------------------------------|--|------------------------------------|--|

|  |  |                             |  |   |  |  |  |
|--|--|-----------------------------|--|---|--|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> |  | 24b. DATE<br><b>6/24/50</b> |  | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven</b> |  | 24d. LOCATION (City, town, or county) (State)<br><b>Glen Burnie, Md.</b> |  |
|--|--|-----------------------------|--|---|--|--|--|

|  |  |  |  |  |  |                                   |  |
|--|--|--|--|--|--|-----------------------------------|--|
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 22 1950</b> |  | REGISTRAR'S SIGNATURE<br><b>Wilmington, Delaware</b> |  | 25. FUNERAL DIRECTOR<br><b>William C. Paul</b> |  | ADDRESS<br><b>1219 St Paul St</b> |  |
|--|--|--|--|--|--|-----------------------------------|--|

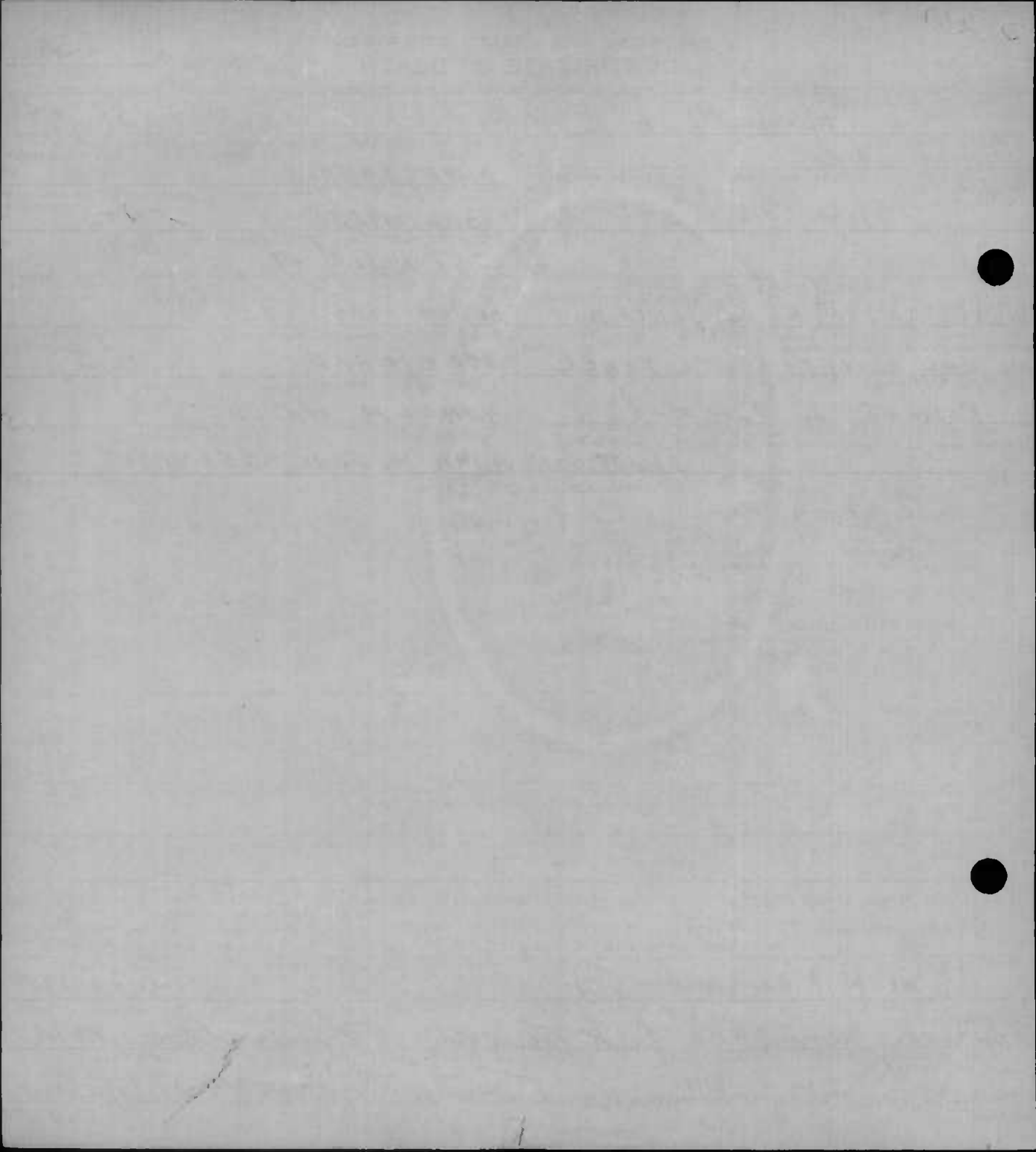




520  
5534BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5534

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Howard L. Funk</b>   |                                  | 2. DATE OF DEATH<br><b>June 21, 1950</b>  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>MARYLAND.</b><br>B. COUNTY |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>251 W. 31<sup>ST</sup> ST.</b>   |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTIMORE 12-06</b>                          |   |
| C. Length of stay in Baltimore<br>Yrs. Mos. Days   |                                  | D. STREET ADDRESS (If rural, give location)<br><b>251 W 31<sup>ST</sup> ST.</b>   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>DIVORCED</b>  | 8. DATE OF BIRTH<br><b>OCT-4 1904</b>             |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>MUTUAL SELLER</b>  |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>RACE TRACK</b>  | 9. AGE (In years last birthday)<br><b>45</b>      |
| 13. FATHER'S NAME<br><b>ROBERT L. FUNK.</b>  |                                  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND.</b>   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br>(If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><b>216-05-0013</b>   | 14. MOTHER'S MAIDEN NAME<br><b>ANNA M. HATCH.</b> |
| 18. <b>420.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>CORONARY DISEASE</b>   |                                  | 17. INFORMANT<br><b>ANNA M. FUNK - 251 W 31<sup>ST</sup> ST</b>   |   |
| DUE TO   |                                  | ADDRESS   |   |
| ANTECEDENT CAUSES  |                                  | INTERVAL BETWEEN ONSET AND DEATH  |   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |                                  | (A) DUE TO  |   |
| (B) DUE TO   |                                  | (C)   |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                                  |   |   |
| 19A. DATE OF OPERATION   |                                  | 19B. MAJOR FINDINGS OF OPERATION  |   |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |   |
| 21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                                       |   |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                                  |   |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                          |   |
| 21F. HOW DID INJURY OCCUR?   |                                  |   |   |
| 22. I certify that I took charge of the remains described above, held an <b>Inspection</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |                                  |   |   |
| 23A. SIGNATURE<br><b>Wm. H. Kammer, Jr.</b>  |                                  | 23B. CHIEF MEDICAL EXAMINER.....<br>ASSISTANT MEDICAL EXAMINER.....<br>MEDICAL INVESTIGATOR.....                                |   |
| 23C. DATE SIGNED<br><b>June 21, 1950</b>   |                                  |   |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 24B. DATE<br><b>June 23/50</b>  |   |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>Park Lawn</b>   |                                  | 24D. LOCATION (City, town, or county) (State)<br><b>Eastern Ave Md</b>  |   |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 22 1950</b>   |                                  | REGISTRAR'S SIGNATURE<br><b>Trustington Williams, Jr.</b>   |   |
| 25. FUNERAL DIRECTOR<br><b>Trustington Williams, Jr.</b>   |                                  | ADDRESS<br><b>3815 Roland 21090 94a</b>   |   |



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5535  
Registered No. \_\_\_\_\_

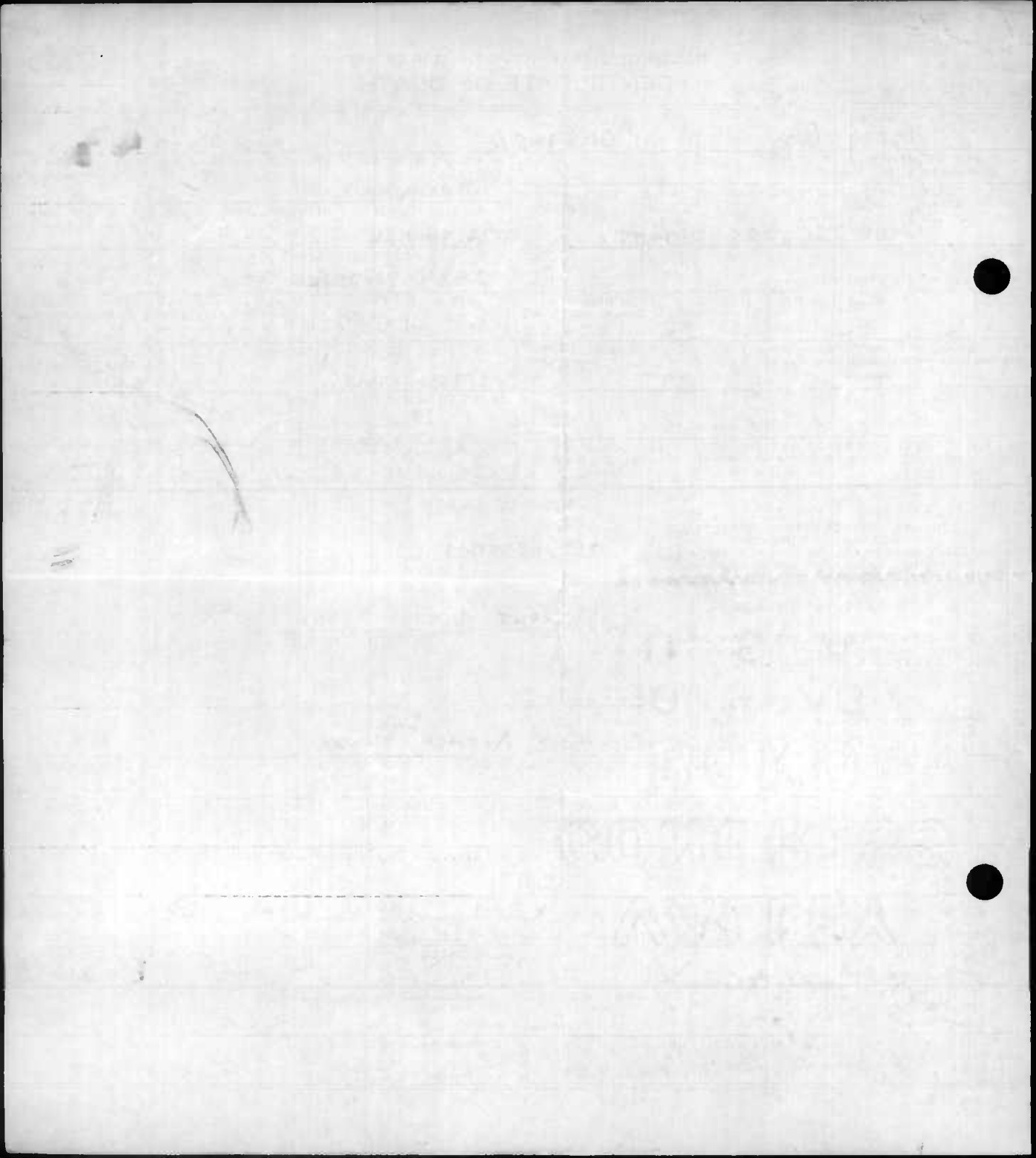
626  
50 5535  
BIRTH NO. 50-12903

|   |                              |   |  |  |   |
|---|------------------------------|---|--|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>BABY BOY MORHISER</b>   |                              |   | 2. DATE OF DEATH <b>6-21-50</b>  |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                              |   | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY _____ |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>BON SECOURS Hospt.</b> |                              |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTIMORE 20-04</b>                               |  |   |
| D. STREET ADDRESS (If rural, give location)<br><b>2434 FREDERICK AVE</b>  |                              |   | E. LENGTH OF STAY IN BALTIMORE<br>Yrs. _____ Mos. _____ Days _____   |  |   |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>S</b> | 8. DATE OF BIRTH<br><b>6-21-50</b>   |  | 9. AGE (In years last birthday)<br><b>-</b>   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                              | 10B. KIND OF BUSINESS OR INDUSTRY                           | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |
| 13. FATHER'S NAME<br><b>Robert Morhiser</b>   |                              |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Ann O'Connor</b>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)   |                              | 16. SOCIAL SECURITY NO.                                     | 17. INFORMANT ADDRESS<br><b>Robert Morhiser - 2434 Frederick Ave</b>   |  |   |

|  |   |
|--|---|
| <p>18. <b>7625</b> CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br/>(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p align="center"><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p align="center"><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> | <p>INTERVAL BETWEEN ONSET AND DEATH</p> |
| <p>(A) <b>ATELECTASIS</b><br/>DUE TO</p> <p>(B) <b>PREMATURITY</b><br/>DUE TO</p> <p>(C) <b>POSSIBLE KIDNEY TUMOR</b></p>  |   |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 19A. DATE OF OPERATION <b>7</b>  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>6-21-1950</b> , to <b>6-21-1950</b> , that I last saw the deceased alive on <b>6-21-1950</b> and that death occurred at <b>9:50</b> p. m., from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE<br><b>George W. Solomon Jr</b>  |  | 23B. ADDRESS<br><b>Bon Secours Hospt</b>  |  | 23C. DATE SIGNED<br><b>6-21-50</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>6-23-50</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Cathedral</b>                              |  |
|  |  | 24D. LOCATION (City, town, or county)<br><b>Baltimore, Md.</b>  |  |   |  |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 22 1950</b> |  | REGISTRAR'S SIGNATURE<br><b>Wilmington Williams, M.D.</b> |  | 25. FUNERAL DIRECTOR ADDRESS<br><b>George W. Foley - Fulton and Fayette St.</b> |  |
|--|--|---|--|---|--|



BIRTH NO.

|   |                               |   |                                     |
|---|-------------------------------|---|-------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Miss Carrie Elizabeth Cochran</i>   |                               | 2. DATE OF DEATH <i>June 21/50</i>  |                                     |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>Bellona Ave</i>  |                               | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <i>md</i> B. COUNTY <i>Balto City</i> |                                     |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Edgewood Sanatorium</i>  |                               | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto md.</i>   |                                     |
| C. Length of stay in Baltimore <i>Life</i>  |                               | D. STREET ADDRESS (If rural, give location) <i>Charles 031st St.</i>  |                                     |
| 5. SEX <i>Female</i>  | 6. COLOR OR RACE <i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>  | 8. DATE OF BIRTH <i>Jan. 5-1859</i> |
| 9. AGE (In years last birthday) <i>91 yrs</i>   |                               | 10. UNDER 1 YEAR Months: Days   | 11. UNDER 24 HOURS Hours: Min.      |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>   |                               | 10B. KIND OF BUSINESS OR INDUSTRY <i>none</i>   |                                     |
| 11. BIRTHPLACE (State or foreign country) <i>Balto md</i>   |                               | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>  |                                     |
| 13. FATHER'S NAME <i>Charles E. Savage</i>  |                               | 14. MOTHER'S MAIDEN NAME <i>Caroline Williams</i>   |                                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>   |                               | 16. SOCIAL SECURITY NO. <i>none</i>   |                                     |
| 17. INFORMANT <i>Miss Sarah Padden (sister)</i>   |                               | ADDRESS <i>Renton</i>   |                                     |
| 18. 443X<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>CAUSE OF DEATH<br>(A) <i>MYOCARDIAL DEGENERATION</i><br>DUE TO<br><br>ANTECEDENT CAUSES<br>(B) <i>HYPERTENSION</i><br>DUE TO<br><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>(C) <i>SENILITY</i> |                               | INTERVAL BETWEEN ONSET AND DEATH<br><i>3 WEEKS</i><br><br><i>10 YEARS</i>   |                                     |
| 19A. DATE OF OPERATION <i>0</i>   |                               | 19B. MAJOR FINDINGS OF OPERATION  |                                     |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               |   |                                     |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                               | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |                                     |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                               |   |                                     |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |                               | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                               |                                     |
| 21F. HOW DID INJURY OCCUR?  |                               |   |                                     |
| 22. I hereby certify that I attended the deceased from <i>1936</i> , 19__, to <i>JUN. 21</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>JUN. 18</i> , 19 <i>50</i> , and that death occurred at <i>12:20 p.m.</i> , from the causes and on the date stated above.  |                               |   |                                     |
| 23A. SIGNATURE <i>W. Hoffmann</i>   |                               | 23B. ADDRESS <i>8 East Read Street. (2)</i>   |                                     |
| 23C. DATE SIGNED <i>6/21/50</i>   |                               |   |                                     |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>   |                               | 24B. DATE <i>June 23/50</i>   |                                     |
| 24C. NAME OF CEMETERY OR CREMATORY <i>Green Mount</i>   |                               | 24D. LOCATION (City, town, or county) (State) <i>Balto md.</i>  |                                     |
| DATE RECEIVED BY LOCAL REGISTRAR <i>JUN 22 1950</i>   |                               | REGISTRAR'S SIGNATURE <i>Huntington</i>   |                                     |
| 25. FUNERAL DIRECTOR <i>Stewart Morris</i>  |                               | ADDRESS <i>Balto</i>  |                                     |

RECEIVED  
JAN 10 1960

RECEIVED  
JAN 10 1960

100-100000

100-100000



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5537  
Registered No.

BIRTH NO.

|   |                                  |   |   |  |  |
|---|----------------------------------|---|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>DAVID VIA</b>   |                                  |   |   | 2. DATE OF DEATH <b>June 22, 1950</b>  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Virginia</b><br>B. COUNTY <b>V-43</b> |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>Franklin Square Hospital</b> |                                  |   |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>(Crozet) Charlottesville</b>                            |  |
| D. Length of stay in Baltimore<br>Yrs. Mos. Days  |                                  |   |   | E. STREET ADDRESS (If rural, give location)  |  |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>married</b> | 8. DATE OF BIRTH<br><b>Feb. 8, 1898</b> |  | 9. AGE (In years last birthday)<br><b>52</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                             |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Construction Co.</b>      |   | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>   |  |
| 13. FATHER'S NAME<br><b>Allan W. Via</b>  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Martha Birkhead</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown)   |                                  | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS<br><b>F.J. Haines - Charlottesville</b>  |  |

|  |  |                                  |
|--|--|----------------------------------|
| 18. <b>463 X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, apnea, etc. It means the disease, injury or complication which caused death.)<br><b>Pulmonary embolism</b><br>DUE TO <b>thrombophlebitis of veins of leg, right</b> |  | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B) _____<br>DUE TO _____<br>(C) _____   |  |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |                                  |

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 19A. DATE OF OPERATION  |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that I took charge of the remains described above, held an <u>autopsy</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |  |  |  |   |  |
| 23A. SIGNATURE<br><i>Stanley B. Duncanson</i> M.D.  |  | 23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/> |  | 23C. DATE SIGNED<br><b>June 22, 1950</b>  |  |

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> |  | 24B. DATE<br><b>6-22-50</b>                         |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Rock Gate</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Crozet - Va.</b> |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 22 1950</b>     |  | REGISTRAR'S SIGNATURE<br><i>Huntington Williams</i> |  | 25. FUNERAL DIRECTOR<br><i>Stewart M. Moore Company</i> |  | ADDRESS<br><b>10013 9849 105 W. North Ave. - City-1</b>              |  |

MINISTÈRE DE LA SANTÉ  
CERTIFICATE OF DEATH

DATE OF DEATH

DECEASED'S NAME

PLACE OF BIRTH

DATE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

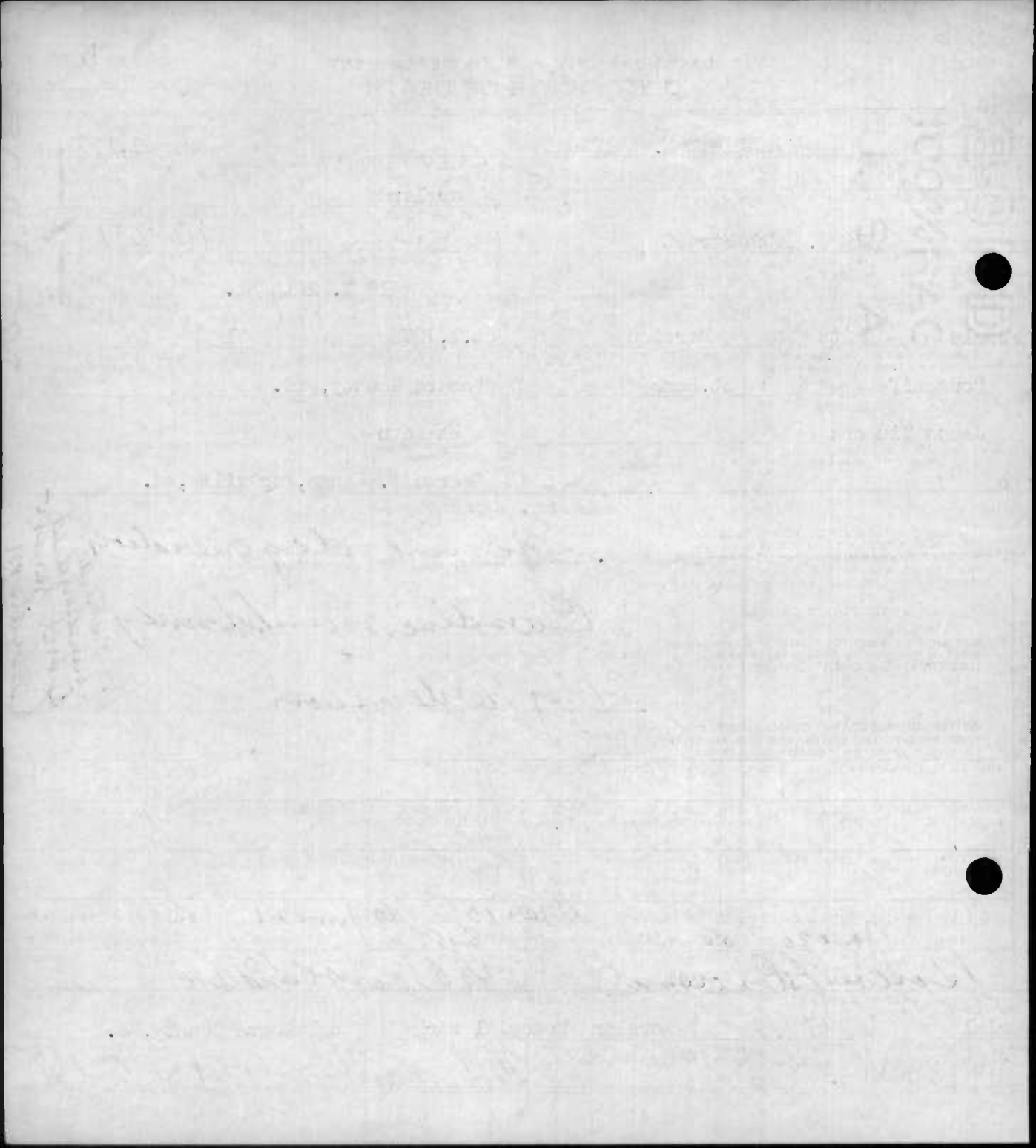
1961-10

1000-1000

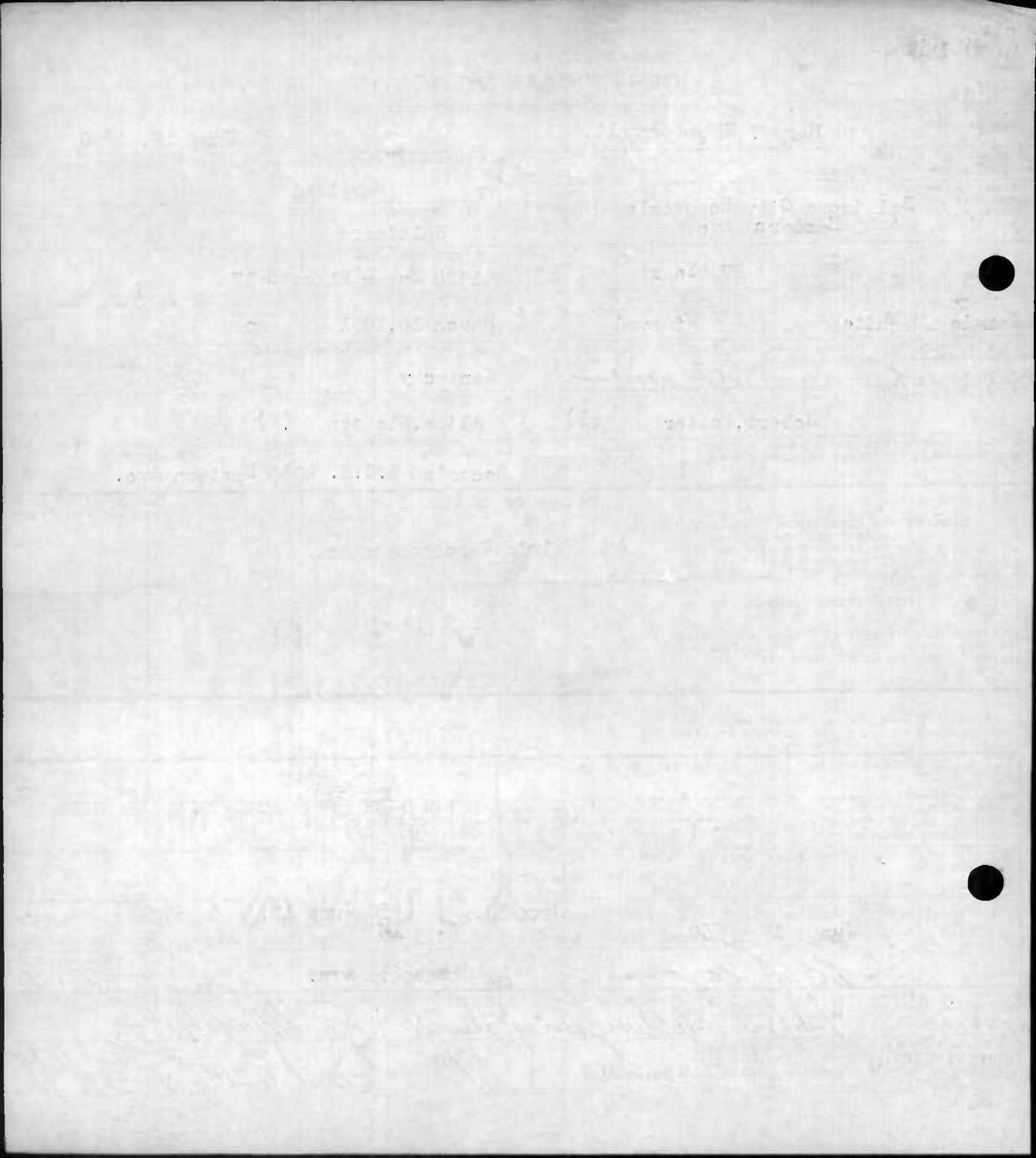
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356  
50 5538BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5538  
Registered No. \_\_\_\_\_

|   |                                  |   |  |   |   |
|---|----------------------------------|---|--|---|---|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>HARRIETT E. WHITMORE</b>   |                                  |   | 2. DATE OF DEATH<br><b>June 21, 1950</b>   |   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY _____ |   |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>519 W. 28th Street</b>  |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 12-07</b>                               |   |   |
| C. Length of stay in Baltimore<br>Yrs. _____<br>Mos. _____<br>Days _____  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>519 W. 28th St.</b>  |   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>   | 8. DATE OF BIRTH<br><b>Oct. 1, 1878</b>  | 9. AGE (In years last birthday)<br><b>71</b>                                      | 10. Under 1 Year<br>Months: _____ Days: _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Howard County, Md.</b>   |   |   |
| 10B. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>   |                                  |   | 12. CITIZEN OF WHAT COUNTRY?<br>_____  |   |   |
| 13. FATHER'S NAME<br><b>James Timmons</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                                  |   | 16. SOCIAL SECURITY NO.<br>_____   |   |   |
| 17. INFORMANT<br><b>George W. Lange, Parkville, Md.</b>   |                                  |   | ADDRESS<br>_____   |   |   |
| 18. <b>443X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br>(A) <b>Senile degeneration</b><br>DUE TO<br>(B) <b>Cardiac insufficiency</b><br>DUE TO<br>(C) <b>Hypertension</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>15.8 years</b><br><b>Physician died</b><br><b>Don't permit</b><br><b>operation</b> |                                  |   |  |   |   |
| 19A. DATE OF OPERATION<br><b>0</b>  |                                  |   | 19B. MAJOR FINDINGS OF OPERATION<br>_____  |   |   |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                  |   |  |   |   |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)<br>_____   |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br>_____                    |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>_____ |   |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>INJURY<br>_____  |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/><br>m. _____ |  | 21F. HOW DID INJURY OCCUR?<br>_____   |   |
| 22. I hereby certify that I attended the deceased from <b>Mar. 13, 1950</b> to <b>June 21, 1950</b> , that I last saw the deceased alive on <b>June 20, 1950</b> , and that death occurred at <b>8:15 P. M.</b> , from the causes and on the date stated above.   |                                  |   |  |   |   |
| 23A. SIGNATURE<br><b>Robert H. Brown</b>  |                                  | 23B. ADDRESS<br><b>2430 Maryland Ave</b>  |  | 23C. DATE SIGNED<br>_____   |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 24B. DATE<br><b>6/24/50</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Park</b>               |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore County, Md.</b>   |                                  | 24E. DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 23 1950</b>   |  | 24F. REGISTRAR'S SIGNATURE<br><b>William H. Williams, M.D.</b>                    |   |
| 24G. FUNERAL DIRECTOR<br><b>William H. Williams, M.D.</b>   |                                  | 24H. ADDRESS<br><b>1217 St Paul St</b>  |  | 24I. DATE<br><b>937</b>   |   |



|  |                                  |  |  |
|--|----------------------------------|--|--|
| <div style="display: flex; justify-content: space-between;"> <span>40 M M 138458<br/>50 5539</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> <span>50 5539</span> </div> <div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b> </div>   |                                  | Registered No. _____   |  |
| BIRTH NO. _____  |                                  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Mary , Ellen Duvall.</b>   |                                  | 2. DATE OF DEATH <b>June 17, 1950</b>  |  |
| 3. PLACE OF DEATH:<br>a. Baltimore City, Maryland<br>b. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>Baltimore City Hospitals</b><br><b>4940 Eastern Ave</b>  |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY _____<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>14-02</b><br>d. STREET ADDRESS (If rural, give location)<br><b>1524 Eutaw Place Z 17</b> |  |
| c. Length of stay in Baltimore <b>27 Years</b><br>Yrs. Mos. Days   |                                  |  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>  |  |
| 13. FATHER'S NAME<br><b>Robert, Petter (D)</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>Kentucky</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>Yes, no or unknown</b>   |                                  | 16. SOCIAL SECURITY NO. _____  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Alice, Cleason (D)</b>  |                                  | 17. INFORMANT ADDRESS<br><b>Records B.C.H. 4940 Eastern Ave.</b>   |  |
| 18. <b>199.1</b> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>(A) <b>Pelvic Carcinomatosis.</b><br>DUE TO<br>ANTECEDENT CAUSES<br>(B) _____<br>DUE TO<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(C) _____<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. _____<br>INTERVAL BETWEEN ONSET AND DEATH _____ |                                  |  |  |
| 19a. DATE OF OPERATION<br><b>0</b>   |                                  | 19b. MAJOR FINDINGS OF OPERATION   |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                                  | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                                  | 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  |
| 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                                  | 21f. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <b>May 30, 1950</b> to <b>June 17, 1950</b> , that I last saw the deceased alive on <b>June 17, 1950</b> , and that death occurred at <b>8:55 AM</b> , from the causes and on the date stated above.  |                                  |  |  |
| 23a. SIGNATURE<br><b>R. S. Crozer</b><br>M. D.   |                                  | 23b. ADDRESS<br><b>4940 Eastern Ave.</b>   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)  |                                  | 24b. DATE<br><b>6/26/50</b>  |  |
| 24c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National Cemetery</b>   |                                  | 24d. LOCATION (City, town, or county) (State)<br><b>Washington, D. C.</b>  |  |
| 25. FUNERAL DIRECTOR<br><b>William Williams</b>  |                                  | 25. ADDRESS<br><b>4214 St Paul St</b>  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 23 1950</b>   |                                  |  |  |



53  
50 5540

information will be sent in

BALTIMORE CITY HEALTH DEPARTMENT

50 5540  
Registered No.

BIRTH NO.

CERTIFICATE OF DEATH

CERTIFICATE CORRECTED

1. NAME OF DECEASED  
(Type or Print)

Robert B. Burnett

2. DATE  
OF  
DEATH

June 22, 50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION  
(If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

22 Walnut St

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Shinnston V-45

D. STREET ADDRESS (If rural, give location)

85.8a

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

6. COLOR OR RACE  
Male White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Married

8. DATE OF BIRTH

8-10-97

9. AGE (In years  
last birthday)  
53 52

If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Coal Miner

10B. KIND OF BUSINESS OR  
INDUSTRY

Coal

11. BIRTHPLACE (State or foreign country)

W. Va., Shinnston

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Burnett

14. MOTHER'S MAIDEN NAME

Hattie Orr

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 162X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

Biobiochemic carcinoma with  
widespread metastases

INTERVAL BETWEEN  
ONSET AND DEATH

4<sup>+</sup> mos.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) .....  
DUE TO  
(C) .....

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

22. I hereby certify that I attended the deceased from June 18, 1950, to June 22, 1950 that I last saw the deceased alive on June 22, 1950 and that death occurred at 4<sup>10</sup> p. m., from the causes and on the date stated above.

23A. SIGNATURE

James C. Vardell, Jr.

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

6-22-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

6/26/50

SHINNSTON MASONIC

SHINNSTON, W. Va.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUN 23 1950

Wm. J. Williams, M.D.

Wm. J. T. K. WER + SONS

454V2

BALTO 17. Md.

47c



1864

March 27

Dear Sir

I have the honor to acknowledge the receipt of your letter of the 25th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Your obedient servant,

J. H. Smith

W. H. Smith

W. H. Smith, Esq.,  
New York City

W. H. Smith

W. H. Smith

W. H. Smith

Very respectfully,  
Your obedient servant,

J. H. Smith

W. H. Smith

W. H. Smith

W. H. Smith

W. H. Smith

400  
0 5541

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5541

|  |  |                                  |  |   |  |   |  |   |  |                               |  |   |  |
|--|--|----------------------------------|--|---|--|---|--|---|--|-------------------------------|--|---|--|
| BIRTH NO.  |  |                                  |  | 1. NAME OF DECEASED<br>(Type or Print) <b>Eyle, Mr. Samuel</b>  |  |   |  | 2. DATE OF DEATH<br><b>June 23, 1950</b>  |  |                               |  |   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |  |                                  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>Harford</b> |  |   |  |   |  |                               |  |   |  |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Church Home + Hosp</b>   |  |                                  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Aberdeen 6200</b>                                  |  |   |  |   |  |                               |  |   |  |
| 6. Length of stay in Baltimore <b>11</b> Yrs. Mos. Days  |  |                                  |  | D. STREET ADDRESS (If rural, give location)<br><b>1 Paradise Road</b>   |  |   |  |   |  |                               |  |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b> |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b>   |  | 8. DATE OF BIRTH<br><b>June 12, 1875</b>                          |  | 9. AGE (In years last birthday)<br><b>75</b>  |  | 10. Under 1 Year Months: Days |  | 11. Under 24 Hours Hours: Min.                |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |  |                                  |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  |   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  |                               |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  |
| 13. FATHER'S NAME<br><b>Eyle, James Henry</b>  |  |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>Smith, Evelyn</b>  |  |   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) |  |                               |  |   |  |
| 16. SOCIAL SECURITY NO.  |  |                                  |  | 17. INFORMANT ADDRESS<br><b>Provoat, Mrs. Elizabeth 1 Paradise Rd. Aberdeen</b>   |  |   |  |   |  |                               |  |   |  |
| 18. <b>446 X</b>   |  |                                  |  | CAUSE OF DEATH  |  |   |  |   |  |                               |  |   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   |  |                                  |  | (A) <b>Nephrosclerosis</b>  |  |   |  | Interval between ONSET AND DEATH<br><b>Many Years</b>   |  |                               |  |   |  |
| ANTECEDENT CAUSES  |  |                                  |  | (B) <b>Generalized Arteriosclerosis</b>   |  |   |  | <b>Many Years</b>   |  |                               |  |   |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  |                                  |  | (C)   |  |   |  |   |  |                               |  |   |  |
| II   |  |                                  |  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                       |  |   |  |   |  |                               |  |   |  |
| 19A. DATE OF OPERATION <b>0</b>  |  |                                  |  | 19B. MAJOR FINDINGS OF OPERATION  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |  |                               |  |   |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |  |                                  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                |  |                               |  |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   |  |                                  |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                |  |   |  | 21F. HOW DID INJURY OCCUR?  |  |                               |  |   |  |
| 22. I hereby certify that I attended the deceased from <b>June 11, 1950</b> , to <b>June 23, 1950</b> , that I last saw the deceased alive on <b>June 23, 1950</b> , and that death occurred at <b>1:10 A.M.</b> , from the causes and on the date stated above. |  |                                  |  |   |  |   |  |   |  |                               |  |   |  |
| 23A. SIGNATURE<br><b>Ronald J. Weston</b>  |  |                                  |  | 23B. ADDRESS<br><b>Church Home Hosp</b>   |  |   |  | 23C. DATE SIGNED<br><b>June 23, 1950</b>  |  |                               |  |   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |                                  |  | 24B. DATE<br><b>6/23/50</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Springfield Cemetery</b> |  | 24D. LOCATION (City, town, or county) (State)<br><b>Perryman, Harford Co. Md.</b>                       |  |                               |  |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 23 1950</b>   |  |                                  |  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b>   |  |   |  | 25. FUNERAL DIRECTOR<br><b>Henry Tarrag + Sons, Aberdeen Md</b>   |  |                               |  |   |  |

MEDICAL CERTIFICATION

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]

[illegible text block]

[illegible text block]

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 5542

|   |                                  |   |  |  |   |
|---|----------------------------------|---|--|--|---|
| BIRTH NO. <u>5542</u>   |                                  | 1. NAME OF DECEASED<br>(Type or Print) <u>SARAH GERTRUDE COLLINS</u>  |  | 2. DATE OF DEATH<br><u>June 20, 1950</u>   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>MARYLAND</u><br>B. COUNTY <u>BALTIMORE</u> |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><u>20-05</u> |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><u>26 North CAREY ST.</u>  |                                  | D. STREET ADDRESS (If rural, give location)<br><u>2645 FREDERICK AVE</u>  |  | E. LENGTH OF STAY IN BALTIMORE<br><u>48 YRS.</u>   |   |
| 5. SEX<br><u>FEMALE</u>   | 6. COLOR OR RACE<br><u>WHITE</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><u>MARRIED</u>   | 8. DATE OF BIRTH<br><u>Sept. 4, 1882</u> | 9. AGE (In years last birthday)<br><u>67</u>   | 10. Under 1 Year Months: Days<br>11. Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>HOME</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u>                                 |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |                                  | 13. FATHER'S NAME<br><u>Tobias REINDOLLAR</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Anna MARTIN</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><u>NO</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>NONE</u>  |  | 17. INFORMANT ADDRESS<br><u>Lottie M. Vox 2648 Lehman ST.</u>                                |   |
| 18. <u>443X</u>   |                                  | CAUSE OF DEATH  |  |  |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   |                                  | (A) <u>Cerebral thrombosis</u>  |  |  |   |
| ANTECEDENT CAUSES   |                                  | DUE TO <u>Hypertension and arteriosclerosis</u>   |  |  |   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONOITION LAST.   |                                  | (B) <u>Cardio-vascular disease</u>  |  |  |   |
|   |                                  | (C) <u>(Left hemiplegia)</u>  |  |  |   |
| II  |                                  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                 |  |  |   |
| 19A. DATE OF OPERATION<br><u>0</u>  |                                  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                     |   |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                     |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                       |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <u>1 June, 1950</u> , to <u>20 June, 1950</u> , that I last saw the deceased alive on <u>19 June, 1950</u> , and that death occurred at <u>1:00 P.M.</u> , from the causes and on the date stated above. |                                  |   |  |  |   |
| 23A. SIGNATURE<br><u>Emil H. Henning Jr.</u>  |                                  | 23B. ADDRESS<br><u>601 Winans Way</u>   |  | 23C. DATE SIGNED<br><u>21 June 50</u>  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |                                  | 24B. DATE<br><u>6-20-50</u>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Mountain View</u>                                   |   |
| 24D. LOCATION (City, town, or county) (State)<br><u>Howard County Md.</u>   |                                  | 25. FUNERAL DIRECTOR ADDRESS<br><u>GEO. E. Schrab 2101 Frederick Ave</u>  |  |  |   |

RECORDS OF THE  
UNITED STATES OF AMERICA

| NAME        |  | RESIDENCE |  | DATE |  |
|-------------|--|-----------|--|------|--|
| J. H. Smith |  | New York  |  | 1880 |  |
| J. H. Smith |  | New York  |  | 1881 |  |
| J. H. Smith |  | New York  |  | 1882 |  |
| J. H. Smith |  | New York  |  | 1883 |  |
| J. H. Smith |  | New York  |  | 1884 |  |
| J. H. Smith |  | New York  |  | 1885 |  |
| J. H. Smith |  | New York  |  | 1886 |  |
| J. H. Smith |  | New York  |  | 1887 |  |
| J. H. Smith |  | New York  |  | 1888 |  |
| J. H. Smith |  | New York  |  | 1889 |  |
| J. H. Smith |  | New York  |  | 1890 |  |
| J. H. Smith |  | New York  |  | 1891 |  |
| J. H. Smith |  | New York  |  | 1892 |  |
| J. H. Smith |  | New York  |  | 1893 |  |
| J. H. Smith |  | New York  |  | 1894 |  |
| J. H. Smith |  | New York  |  | 1895 |  |
| J. H. Smith |  | New York  |  | 1896 |  |
| J. H. Smith |  | New York  |  | 1897 |  |
| J. H. Smith |  | New York  |  | 1898 |  |
| J. H. Smith |  | New York  |  | 1899 |  |
| J. H. Smith |  | New York  |  | 1900 |  |

|   |   |  |
|---|---|--|
| <div style="display: flex; justify-content: space-between;"> <span>620<br/>50 5543</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> <span>X 50 5543</span> </div>   |   |  |
| <div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. 50-10 233</span> <span>CERTIFICATE OF DEATH</span> <span>Registered No.</span> </div>  |   |  |
| 1. NAME OF DECEASED (Type or Print) <b>Audrey Cecilia Ayers</b>   |   | 2. DATE OF DEATH <b>6/12/50</b>  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>Provident Hospital</b>   |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore (TOWSON)</b>                                    |
| D. LENGTH OF STAY IN BALTIMORE <b>24</b> Yrs. <input checked="" type="checkbox"/> Mos. <input type="checkbox"/> Days  |   | E. STREET ADDRESS (If rural, give location)<br><b>311 E. Pennsylvania Ave.</b>   |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>Negro</b>   | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  |
| 8. DATE OF BIRTH <b>5/19/50</b>   |   | 9. AGE (In years last birthday) <b>24</b>  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |   | 10B. KIND OF BUSINESS OR INDUSTRY  |
| 11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?   |
| 13. FATHER'S NAME <b>Thomas Raymond Ayers</b>   |   | 14. MOTHER'S MAIDEN NAME <b>Frances Jane Morris</b>  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |   | 16. SOCIAL SECURITY NO.  |
| 17. INFORMANT <b>mother</b>   |   | ADDRESS <b>311 E. Pennsylvania Ave.</b>  |
| 18. <b>763.5</b> CAUSE OF DEATH   |   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>(A) <b>Infectious Diarrhea</b>              |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B) <b>Prematurity</b>  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |   |  |
| 19A. DATE OF OPERATION <b>0</b>   |   | 19B. MAJOR FINDINGS OF OPERATION   |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |
| 22. I hereby certify that I attended the deceased from <b>5/19/50</b> to <b>6/12/50</b> , that I last saw the deceased alive on <b>6/12/50</b> , and that death occurred at <b>1:40 P. M.</b> , from the causes and on the date stated above. |   |  |
| 23A. SIGNATURE <b>W. B. Bantley</b> M. D.   |   | 23B. ADDRESS <b>2233 Sanjour Ave.</b>  |
| 23C. DATE SIGNED <b>6/15/50</b>   |   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   | 24B. DATE   | 24C. NAME OF CEMETERY OR CREMATORY <b>JOHN HOPKINS MEDICAL SCHOOL</b>  |
| 24D. LOCATION (City, town, or county) (State) <b>JUN 20 1950</b>  |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR <b>JUN 23 1950</b>   |   | REGISTRAR'S SIGNATURE <b>Huntington Williams, Jr.</b>  |
| 25. FUNERAL DIRECTOR <b>Commissioner of Health</b>  |   | ADDRESS  |



RECEIVED JUL 2 1950  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.



620  
0 5544BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5544  
Registered No.

|   |                              |   |   |   |   |
|---|------------------------------|---|---|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <u>Lula A. Bowers</u>  |                              |   | 2. DATE OF DEATH <u>June 22, 1950</u>   |   |   |
| 3. PLACE OF DEATH:<br>a. <u>Baltimore City, Maryland</u>  |                              |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>Maryland</u><br>B. COUNTY <u>Baltimore</u> |   |   |
| b. FULL NAME OF HOSPITAL OR INSTITUTION<br><u>Union Memorial Hospital</u>   |                              |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><u>Baltimore</u> <u>27-03</u>                                   |   |   |
| d. LENGTH OF STAY IN BALTIMORE <u>64</u>  |                              |   | e. STREET ADDRESS (If rural, give location)<br><u>3006 Southern Ave.</u>  |   |   |
| 5. SEX<br><u>F</u>  | 6. COLOR OR RACE<br><u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><u>M</u> | 8. DATE OF BIRTH<br><u>July 24, 1895</u>  | 9. AGE (In years, last birthday)<br><u>64</u> | 10. Under 1 Year<br>Months: <u>6</u> Days: <u>4</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                              |   | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |   |   |
| 13. FATHER'S NAME<br><u>Frederick Siegman</u>   |                              |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>   |                              |   | 16. SOCIAL SECURITY NO.<br><u>212-05-9486</u>   |   |   |
| 17. INFORMANT<br><u>Mr. Glenn A. Bowers</u>   |                              |   | 18. ADDRESS<br><u>3006 Southern Ave.</u>  |   |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><u>Subdiaphragmatic abscess, bilateral</u><br>DUE TO<br><u>Perforating sigmoid, transverse colon and cecum</u><br><u>Lobar pneumonia, lt.</u> |                              |   | INTERVAL BETWEEN ONSET AND DEATH  |   |   |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><u>II</u><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                              |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |
| 19a. DATE OF OPERATION<br><u>April 25, 1950</u>   |                              |   | 19b. MAJOR FINDINGS OF OPERATION<br><u>Vesico-sigmoidal fistula</u>   |   |   |
| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                              |   | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   |   |
| 21c. WHERE DID INJURY OCCUR?  |                              |   | 21d. TIME (Month) (Day) (Year) (Hour)   |   |   |
| 21e. INJURY OCCURRED  |                              |   | 21f. HOW DID INJURY OCCUR?  |   |   |
| 21g. INJURY   |                              |   | 21h. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   |   |
| 22. I hereby certify that I attended the deceased from <u>April 23, 1950</u> , to <u>June 22, 1950</u> , that I last saw the deceased alive on <u>June 22, 1950</u> , and that death occurred at <u>6:45</u> m., from the causes and on the date stated above.  |                              |   |   |   |   |
| 23a. SIGNATURE<br><u>Dr. Marshall D. Carrier, Jr.</u>   |                              |   | 23b. ADDRESS<br><u>Union Memorial Hosp.</u>   |   |   |
| 23c. DATE SIGNED<br><u>6-22-50</u>  |                              |   | 23d. M. D.  |   |   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                              |   | 24b. DATE<br><u>June 24, 1950</u>   |   |   |
| 24c. NAME OF CEMETERY OR CREMATORY<br><u>Baltimore</u>  |                              |   | 24d. LOCATION (City, town, or county) (State)<br><u>Baltimore Md</u>  |   |   |
| 24e. LOCAL REGISTRAR<br><u>UN 23 1950</u>   |                              |   | 24f. REGISTRAR'S SIGNATURE<br><u>Wilmington Williams, M.D.</u>  |   |   |
| 24g. FUNERAL DIRECTOR<br><u>H. J. Anderson &amp; Sons, Inc.</u>   |                              |   | 24h. ADDRESS<br><u>Baltimore Md</u>   |   |   |

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

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|--|---------------------------|---|---|--|---|
| <div style="font-size: 2em; margin: 0;">400</div> <div style="font-size: 1.5em; margin: 0;">50 5545</div>  |                           | <div style="font-size: 1.5em; margin: 0;">3E.9357</div> <div style="font-size: 1.5em; margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</div> <div style="font-size: 1.5em; margin: 0;">CERTIFICATE OF DEATH</div> |   | <div style="font-size: 1.5em; margin: 0;">50 5545</div> <div style="font-size: 1.2em; margin: 0;">Registered No. _____</div> |   |
| BIRTH NO. _____  |                           |   |   |  |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>THOMAS BUELL</b>   |                           |   | 2. DATE OF DEATH <b>June 9, 1950</b>  |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                           |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE _____ B. COUNTY _____ |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>2305 ST PAUL ST<br/>ST PAUL CONVALESCENT HOME</b>   |                           |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTIMORE, 18, MARYIA MD</b>         |  |   |
| D. STREET ADDRESS (If rural, give location)<br><b>2305 St. Paul St. 324-E 20th St</b>  |                           |   |   |  |   |
| E. Length of stay in Baltimore ?   |                           |   | F. Yrs. Mos. Days   |  |   |
| 5. SEX <b>M</b>  | 6. COLOR OR RACE <b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>U</b>  | 8. DATE OF BIRTH <b>U</b>   | 9. AGE (In years last birthday) <b>58 yrs</b>  | 10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                           | 10B. KIND OF BUSINESS OR INDUSTRY <b>K</b>  | 11. BIRTHPLACE (State or foreign country) <b>K</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>N</b>                         |
| 13. FATHER'S NAME <b>N O</b>   |                           |   | 14. MOTHER'S MAIDEN NAME <b>O</b>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>H</b>   |                           | 16. SOCIAL SECURITY NO. <b>N</b>  | 17. INFORMANT <b>N</b> ADDRESS _____  |  |   |
| 18. <b>163X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Carcinoma of lungs</b><br>DUE TO (A) _____<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO (B) _____<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>DUE TO (C) _____ |                           |   | CAUSE OF DEATH<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>1 yr</b>   |  |   |
| 19A. DATE OF OPERATION <b>0</b>  |                           | 19B. MAJOR FINDINGS OF OPERATION  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |                           | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |   |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   |                           | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <b>June 1</b> , 19 <b>50</b> , to <b>June 9</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>June 8, 1950</b> , and that death occurred at <b>5:00 A.m.</b> , from the causes and on the date stated above.  |                           |   |   |  |   |
| 23A. SIGNATURE <b>E. Ellsworth Cook</b>  |                           | 23B. ADDRESS <b>2431 Maryland Avenue</b>  |   | 23C. DATE SIGNED <b>6/14/50</b>  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  |                           | 24B. DATE   |   | 24C. NAME OF CEMETERY OR CREMATORY   |   |
| 24D. LOCATION (City, town, or county) (State)  |                           | 24E. DATE RECEIVED BY LOCAL REGISTRAR <b>JUN 23 1950</b>  |   | 24F. REGISTRAR'S SIGNATURE <b>Huntington Williams</b>  |   |
| 24G. DATE RECEIVED BY LOCAL REGISTRAR  |                           | 24H. REGISTRAR'S SIGNATURE  |   | 24I. FUNERAL DIRECTOR <b>University Medical School</b>   |   |
| 24J. ADDRESS   |                           | 24K. ADDRESS  |   | 24L. ADDRESS   |   |

THE UNIVERSITY OF CHICAGO  
LIBRARY OF THE DIVISION OF THE PHYSICAL SCIENCES

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1960

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No.

50 5546

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN R. PHILLIPS

2. DATE  
OF  
DEATH

June 10, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

Mercy Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL, and give township)

Baltimore

5-01

D. STREET ADDRESS (If rural, give location)

5 N. Exeter Street

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

U

Yrs.  
Mos.  
Days

8. DATE OF BIRTH

U

9. AGE (In years last birthday)

43

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

K

11. BIRTHPLACE (State or foreign country)

K

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

N

14. MOTHER'S MAIDEN NAME

O

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

N

17. INFORMANT

W

ADDRESS

N

18. 002X

**CAUSE OF DEATH**

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary tuberculosis

DOE TO

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DOE TO

**II**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

*R. S. Fisher*

M.D.

23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED June 12, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Wilmington Williams, M.D.*

25. FUNERAL DIRECTOR

ADDRESS

*Commissioner of Health*

UNIVERSITY MEDICAL SCHOOL JUN 19 1950

CERTIFICATE OF DEATH

7

10

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No.

50 5547

BIRTH NO.

50 5547

|  |                                    |  |                  |
|--|------------------------------------|--|------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>VERNON DABNEY</b>  |                                    | 2. DATE OF DEATH<br><b>June 10, 1950</b>   |                  |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>   |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |                  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>Franklin Square Hospital</b><br>(DoA) |                                    | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>18-02</b>                  |                  |
| Length of stay in Baltimore<br>Yrs. Mos. Days  |                                    | D. STREET ADDRESS (If rural, give location)<br><b>1076 W. Fairmount Avenue</b>   |                  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Colored</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  | 8. DATE OF BIRTH |
| 9. AGE (in years last birthday)<br><b>60</b>   |                                    | If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.  |                  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>U</b>                          |                                    | 10B. KIND OF BUSINESS OR INDUSTRY  |                  |
| 11. BIRTHPLACE (State or foreign country)  |                                    | 12. CITIZEN OF WHAT COUNTRY?   |                  |
| 13. FATHER'S NAME<br><b>N K</b>  |                                    | 14. MOTHER'S MAIDEN NAME<br><b>N</b>   |                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)<br><b>O</b>                                   |                                    | 16. SOCIAL SECURITY NO.  |                  |
| 17. INFORMANT<br><b>N</b>  |                                    | ADDRESS  |                  |

|  |                                  |
|--|----------------------------------|
| 18. <b>443 X W</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>(A) Hypertensive heart disease</b><br>DUE TO<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>(B)</b><br>DUE TO<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>(C) Obesity</b> | INTERVAL BETWEEN ONSET AND DEATH |
|--|----------------------------------|

|   |   |   |
|---|---|---|
| 19A. DATE OF OPERATION  | 19B. MAJOR FINDINGS OF OPERATION  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |

I certify that I took charge of the remains described above, held an **Inspection & Inquiry** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

|                                    |   |  |
|------------------------------------|---|--|
| 23A. SIGNATURE<br><i>B. Fisher</i> | 23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/> | 23C. DATE SIGNED<br><b>June 12, 1950</b> |
|------------------------------------|---|--|

|  |           |   |   |
|--|-----------|---|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)              | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY  | 24D. LOCATION (City, town, or county) (State) |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 23 1950</b> |           | REGISTRAR'S SIGNATURE<br><i>William H. Williams, M.D.</i><br>25. FUNERAL DIRECTOR<br><i>Commissioner of Health</i><br>ADDRESS |   |

**UNIVERSITY MEDICAL SCHOOL JUN 19 1950**

93D ✓





| BALTIMORE CITY HEALTH DEPARTMENT  |  |  |  | X Registered No. 50 5548  |  |
|---|--|--|--|---|--|
| BIRTH NO. 5548 50-123,26  |  |  |  | CERTIFICATE OF DEATH  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Baby Virginia Hurtt</i>   |  | 2. DATE OF DEATH <i>June 29, 1950</i>  |  |   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Md</i> B. COUNTY <i>Baltimore</i> |  |   |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>JOHNS HOPKINS HOSPITAL</i>  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore Rural</i>                                 |  |   |  |
| D. STREET ADDRESS (If rural, give location)<br><i>123 Balnear Ave 5300</i>  |  | E. LENGTH OF STAY IN BALTIMORE<br><i>33</i>  |  |   |  |
| 5. SEX <i>Female</i>  |  | 6. COLOR OR RACE <i>Colored</i>  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)                         |  |
| 8. DATE OF BIRTH <i>6-19-50</i>   |  | 9. AGE (In years last birthday)  |  | 10. Under 1 Year Months: Days   |  |
| 11. BIRTHPLACE (State or foreign country)   |  | 12. CITIZEN OF WHAT COUNTRY?   |  | 13. FATHER'S NAME <i>Charles Hurtt</i>                                  |  |
| 14. MOTHER'S MAIDEN NAME <i>Virginia ?</i>  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                               |  | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i>   |  | ADDRESS  |  | 18. CAUSE OF DEATH  |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   |  | (A) <i>Miliary Atelectasis</i>   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| 20. ANTECEDENT CAUSES   |  | (B) <i>Prematurity -</i>   |  |   |  |
| 21. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  | (C)  |  |   |  |
| 22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |  |  |   |  |
| 23. DATE OF OPERATION <i>0</i>  |  | 24. MAJOR FINDINGS OF OPERATION  |  | 25. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 26. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  |  | 27. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |  | 28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 29. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 30. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                  |  | 31. HOW DID INJURY OCCUR?   |  |
| 32. I hereby certify that I attended the deceased from <i>6/19</i> , 19 <i>50</i> , to <i>6/20</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>6/20</i> , 19 <i>50</i> , and that death occurred at <i>m.</i> , from the causes and on the date stated above. |  | 33. SIGNATURE <i>Robert E. Jackson M.D.</i>  |  | 34. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>                               |  |
| 35. DATE RECEIVED BY LOCAL REGISTRAR <i>JUN 23 1950</i>   |  | 36. REGISTRAR'S SIGNATURE <i>Robert E. Jackson M.D.</i>  |  | 37. FUNERAL DIRECTOR ADDRESS  |  |
| 38. BURIAL, CREMATION, REMOVAL (Specify)  |  | 39. DATE   |  | 40. NAME OF CEMETERY OR CREMATORY <i>Hop Buryal</i>                     |  |
| 41. LOCATION (City, town, or county)  |  | (State)  |  | 42. DATE SIGNED <i>6/21/50</i>  |  |
| VS 150  |  | 159  |  |   |  |

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## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 50 5549

BIRTH NO. 33

1. NAME OF DECEASED  
(Type or Print)

Baby girl Proctor #78775

2. DATE  
OF  
DEATH

JUN 19 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
A. STATE B. COUNTY before admission)

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

10-01

D. STREET ADDRESS (If rural, give location)

1014 Stirling St

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Charles S. Proctor

14. MOTHER'S MAIDEN NAME

Anna Jenkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 776 X I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Prematurity

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from 19 to 19, that I last saw the  
deceased alive on 6-19-1950 and that death occurred at 11:40 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

JOHNS HOPKINS HOSPITAL

6/21/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

05551

159

*Handwritten notes at top right.*

Baby girl

Proctor 44222

md

Baltimore

1014 Stirling St

10-17-20

md

1014 Stirling St  
Baltimore

more copies

1014 Stirling St

11407

10-17-20

*Handwritten notes at bottom right.*

212

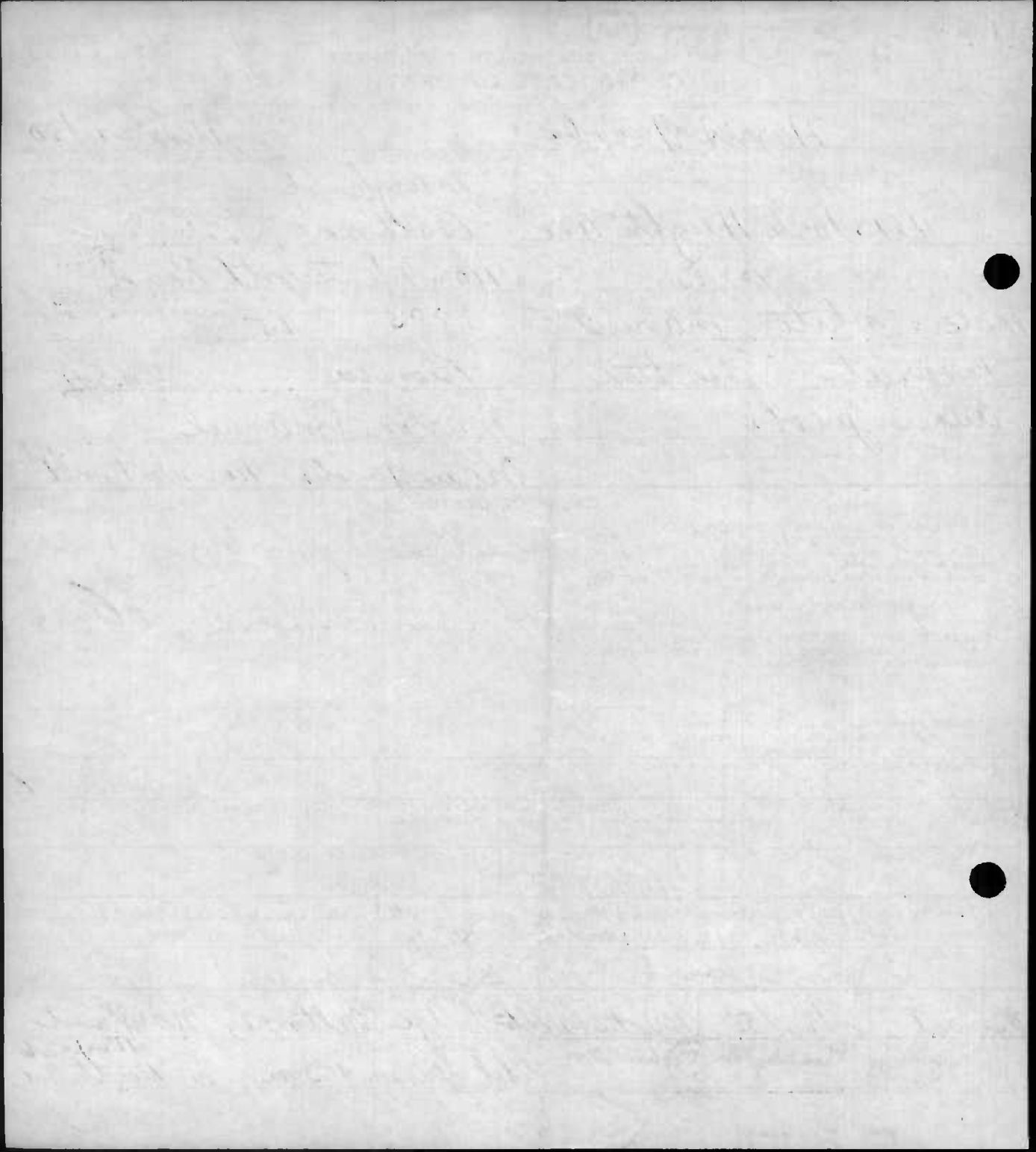
5550

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5550

Registered No.

|  |   |   |   |
|--|---|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Harris Jacobs</i>  |   | 2. DATE OF DEATH<br><i>June 22/50</i>   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |   | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY |   |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>4613 Park Heights Ave</i>  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 28-02</i>                      |   |
| 6. Length of stay in Baltimore <i>40 YRS.</i>  |   | D. STREET ADDRESS (If rural, give location)<br><i>4102 Wentworth Road</i>   |   |
| 5. SEX<br><i>Male</i>  | 6. COLOR OR RACE<br><i>White</i>  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Married</i>   | 8. DATE OF BIRTH<br><i>1885</i>               |
| 9. AGE (in years last birthday)<br><i>65</i>   |   | 10. Under 1 Year<br>Months: Days  | 11. Under 24 Hours<br>Hours: Min.             |
| 10A. USUAL OCCUPATION (Give kind of work doing most of working life, even if retired)<br><i>Proprietor</i>   |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Shoe Store</i>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><i>Russia</i>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |   |
| 13. FATHER'S NAME<br><i>Asker Jacobs</i>   |   | 14. MOTHER'S MAIDEN NAME<br><i>Marion Emanuel</i>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)   |   | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><i>Oscar Jacobs - 4102 Wentworth Rd.</i>  |   | ADDRESS   |   |
| 18. <i>331X I</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Cerebral hemorrhage</i><br>DUE TO<br><i>Hypertension</i><br>DUE TO<br><i>6 yrs</i> |   | INTERVAL BETWEEN ONSET AND DEATH  |   |
| 19. DATE OF OPERATION  |   | 19B. MAJOR FINDINGS OF OPERATION  |   |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |   |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |
| 21D. TIME (Month) (Day) (Year) (Hour)  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I hereby certify that I attended the deceased from <i>Jan 1944</i> to <i>Jun 22, 1950</i> , that I last saw the deceased alive on <i>Jun 21, 1950</i> , and that death occurred at <i>4:30 p.m.</i> , from the causes and on the date stated above.  |   |   |   |
| 23A. SIGNATURE<br><i>Iwin Hunter</i> M.D.  |   | 23B. ADDRESS<br><i>3003 Garrison Blvd</i>   |   |
| 23C. DATE SIGNED<br><i>6-22-50</i>   |   |   |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Removal</i>  | 24B. DATE<br><i>6/23/50</i>   | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Greater Balt. Lodge Baltimore, Maryland</i>  | 24D. LOCATION (City, town, or county) (State) |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUN 23 1950</i>   | REGISTRAR'S SIGNATURE<br><i>Washington Williams, M.D.</i>   | 25. FUNERAL DIRECTOR<br><i>Sol. Johnson &amp; Bros</i>  | ADDRESS<br><i>W. North Ave.</i>               |





452

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5551

BIRTH NO. 5551

|  |                           |  |  |  |  |
|--|---------------------------|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>REBEKAH WILLIAMS</b>   |                           |  | 2. DATE OF DEATH <b>6-22-50</b>  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                           |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Hosp. for the Women of Maryland</b>                           |                           |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>  |  |  |
| D. STREET ADDRESS (If rural, give location) <b>Lutherville 5300</b>                                      |                           |  | E. LENGTH OF STAY IN BALTIMORE   |  |  |
| 5. SEX <b>F</b>  | 6. COLOR OR RACE <b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b> | 8. DATE OF BIRTH <b>2-20-1874</b>  |  | 9. AGE (In years last birthday) <b>76</b>  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H. W.</b> |                           | 10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>                  | 11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> |
| 13. FATHER'S NAME <b>Charles Watkins</b>   |                           |  | 14. MOTHER'S MAIDEN NAME <b>Virginia Over</b>  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, on or unknown) <b>No</b>                              |                           | 16. SOCIAL SECURITY NO.  | 17. INFORMANT <b>Mrs. Ambler Moss</b>  |  |  |
|  |                           |  | ADDRESS <b>Brookland</b>   |  |  |

MEDICAL CERTIFICATION

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| 18. <b>420.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Coronary Occlusion - Acute</b> |  |  | INTERVAL BETWEEN ONSET AND DEATH                    |  |  |
| DUE TO   |  |  |   |  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  |  | DUE TO  |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |  |   |  |  |
| 19A. DATE OF OPERATION <b>0</b>  |  | 19B. MAJOR FINDINGS OF OPERATION   |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? <b>7:15 P.M.</b>                              |   |  |  |
| 22. I hereby certify that I attended the deceased from <b>6-22, 1950</b> to <b>6-22, 1950</b> , that I last saw the deceased alive on <b>6-22, 1950</b> , and that death occurred at <b>10:45 p.m.</b> , from the causes and on the date stated above.   |  |  |   |  |  |
| 23A. SIGNATURE <b>Wm. P. Benson, Jr.</b>   |  | 23B. ADDRESS <b>Women's Hosp.</b>  |   | 23C. DATE SIGNED <b>6-22-50</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>   |  | 24B. DATE <b>June 24/50</b>  | 24C. NAME OF CEMETERY OR CREMATORY <b>Hollywood</b> | 24D. LOCATION (City, town, or county) (State) <b>Richmond Va</b>                 |  |
| DATE RECEIVED BY LOCAL REGISTRAR <b>JUN 23 1950</b>  |  | REGISTRAR'S SIGNATURE <b>Hennington Williams, M.D.</b>                   |   | 25. FUNERAL DIRECTOR <b>Henry W. Jenkins Sons Co</b> ADDRESS <b>4905 York Rd</b> |  |

STATE OF NEW YORK  
CERTIFICATE OF DEATH

NAME OF DECEASED *John Doe*

AGE *45* YEARS

SEX *Male*

DATE OF DEATH *Jan 15 1900*

PLACE OF DEATH *New York City*

Cause of Death *Heart Disease*

Signature of Physician *Dr. J. Smith*

Signature of Registrar *John Doe*

Signature of Coroner *John Doe*

Signature of Minister of the Gospel *John Doe*

Signature of Undertaker *John Doe*

Signature of Burial Officer *John Doe*

Signature of Health Officer *John Doe*

Signature of Police Officer *John Doe*

Signature of Fire Officer *John Doe*

Signature of Street Officer *John Doe*

Signature of Water Officer *John Doe*

Signature of Sewer Officer *John Doe*

Signature of Gas Officer *John Doe*

Signature of Electric Officer *John Doe*

Signature of Telephone Officer *John Doe*

Signature of Fire Alarm Officer *John Doe*

620  
50 5552BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5552  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

RUTH O BERKOW

2. DATE  
OF  
DEATH

6-22-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

Seville apts 2C

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

D. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

Joseph

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Louis Berkow

Same

18. 170X1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of breast with metastasis generally

DUE TO

2 1/2 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

Jul 1948

19B. MAJOR FINDINGS OF OPERATION

Carcinoma of breast

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jul 30 1948, to June 22, 1950, that I last saw the deceased alive on June 22, 1950, and that death occurred at 4:47 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Herbert H. Grunshamer Jr.

M. D.

23B. ADDRESS

Riviera Apts Lake Drive

23C. DATE SIGNED

June 22, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

6-23-50

24C. NAME OF CEMETERY OR CREMATORY

United Hebrew

24D. LOCATION (City, town, or county) (State)

Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR

JUN 23 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Jack Lewis Inc 2100 Eastward Pl

ADDRESS

Gunderheimer  
Reveria  
Codova Drive  
729-Lake  
Apt. 71

500  
50 5553BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5553  
Registered No.

|  |                               |   |   |
|--|-------------------------------|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>ESTHER H. SHANE</b>  |                               | 2. DATE OF DEATH <b>6-22-50</b>   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                               | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Md</b> B. COUNTY |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>3604 Cottage Ave</b>  |                               | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 15-12</b>                   |   |
| C. Length of stay in Baltimore <b>41</b> Yrs. <input checked="" type="checkbox"/> Mos. <input type="checkbox"/> Days   |                               | D. STREET ADDRESS (If rural, give location) <b>3604 Cottage Ave</b>   |   |
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>  | 8. DATE OF BIRTH <b>88</b>                              |
| 9. AGE (In years last birthday) <b>62</b>  |                               | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>           | 11. BIRTHPLACE (State or foreign country) <b>Russia</b> |
| 12. CITIZEN OF WHAT COUNTRY?   |                               | 13. FATHER'S NAME <b>Abraham</b>  |   |
| 14. MOTHER'S MAIDEN NAME <b>Sarah</b>  |                               | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes, no or unknown</b>         |   |
| 16. SOCIAL SECURITY NO.  |                               | 17. INFORMANT <b>Morris Shane</b> ADDRESS <b>Jame</b>   |   |
| 18. <b>450.0 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br>(A) <b>Pneumonia</b><br>DUE TO<br>(B) <b>Seuslity</b><br>DUE TO<br>(C) <b>Arteriosclerosis</b><br>INTERVAL BETWEEN ONSET AND DEATH |                               |   |   |
| 19. DATE OF OPERATION <b>0</b> 19A. MAJOR FINDINGS OF OPERATION  |                               |   |   |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                               | 21. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |   |
| 21A. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  |                               | 21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |
| 21C. TIME (Month) (Day) (Year) (Hour) <b>June 21, 1950</b>   |                               | 21D. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK                |   |
| 21E. HOW DID INJURY OCCUR?   |                               | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I hereby certify that I attended the deceased from <b>1945</b> , 19 <b>10</b> , to <b>June 21</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>June 21, 1950</b> , and that death occurred at <b>7:30 p.m.</b> , from the causes and on the date stated above.  |                               |   |   |
| 23A. SIGNATURE <b>Morris A. Jones</b> M. D.  |                               | 23B. ADDRESS <b>3643 Reisterstown Rd</b>  |   |
| 23C. DATE SIGNED <b>6/22/50</b>  |                               | 24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |   |
| 24B. DATE <b>6-22-50</b>   |                               | 24C. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>  |   |
| 24D. LOCATION (City, town, or county) <b>Baltimore Md</b>  |                               | 24E. DATE RECEIVED BY LOCAL REGISTRAR <b>JUN 23 1950</b>  |   |
| 24F. REGISTRAR'S SIGNATURE <b>Thurston Williams</b>  |                               | 24G. FUNERAL DIRECTOR <b>Jack Reuter</b> ADDRESS <b>2100 Eutaw Rd</b>   |   |

WALLEY

COLLIERIES

BOND

COMPANY

INCORPORATED

IN THE STATE OF

NEW YORK

FOR THE

RECORD

OF THE

OFFICE OF THE

CLERK OF THE

COURT

IN THE



To be approved by chief

Medical Examiner

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5554

Registered No.

BIRTH NO. 5554

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <u>Louis Seidenman</u>  |  |  | 2. DATE OF DEATH <u>6/22/50</u>   |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <u>Baltimore, Maryland</u><br>B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><u>Union Memorial Hospt.</u> |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>Maryland</u><br>C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u><br>D. STREET ADDRESS (If rural, give location) <u>1701 Eutaw Place</u> |  |  |
| 5. SEX <u>Male</u>   |  |  | 6. COLOR OR RACE <u>White</u>   |  |  |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>   |  |  | 8. DATE OF BIRTH <u>Oct. 2, 1887</u>  |  |  |
| 9. AGE (In years last birthday) <u>62</u>  |  |  | 10. UNDER 1 Year Months: Days   |  |  |
| 11. UNDER 24 Hours Hours: Min.   |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |  |
| 13. FATHER'S NAME <u>Salig Seidenman</u>   |  |  | 14. MOTHER'S MAIDEN NAME <u>Mary Seidenberg</u>   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Unknown</u>   |  |  | 16. SOCIAL SECURITY NO.   |  |  |
| 17. INFORMANT <u>Helen Seidenman (wife) - Same</u>   |  |  | ADDRESS   |  |  |

18. 4/20/1

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) Embolism of abdominal aorta  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary thrombosis  
DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

## CERTIFICATION APPROVED BY

Dr. Kammer

per R. B. Fisher

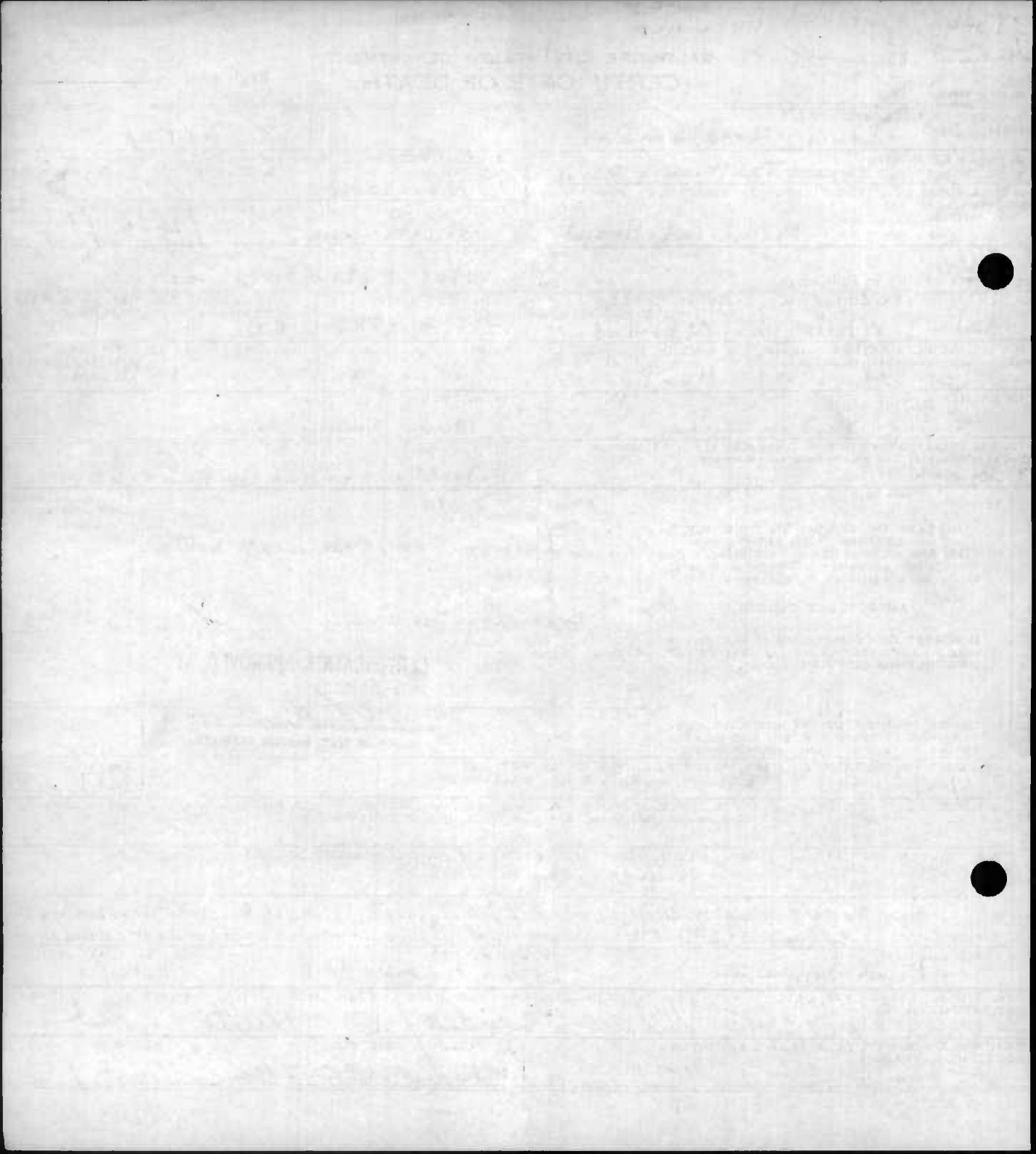
M. D.

CHIEF OR ASST. MEDICAL EXAMINER.

3 weeks

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 19A. DATE OF OPERATION <u>6/22/50</u>   |  | 19B. MAJOR FINDINGS OF OPERATION <u>Embolism in both common iliacs</u>                                 |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)         |  |
| 21D. TIME (Month) (Day) (Year) (Hour)   |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <u>6/22</u> , 19 <u>50</u> , to <u>6/22</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>6/22</u> , 19 <u>50</u> , and that death occurred at <u>2 P.</u> m., from the causes and on the date stated above. |  |  |  |  |  |
| 23A. SIGNATURE <u>J. Frank Supple, III</u>  |  | 23B. ADDRESS <u>Union Memorial Hosp.</u>   |  | 23C. DATE SIGNED <u>6/24/50</u>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 24B. DATE <u>6-23-50</u>   |  | 24C. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendshep</u>                      |  |
| 24D. LOCATION (City, town, or county) <u>Balto</u>  |  | 24E. STATE <u>Md</u>   |  | 24F. DATE RECEIVED BY LOCAL REGISTRAR <u>JUN 23 1950</u>                         |  |
| 24G. REGISTRAR'S SIGNATURE <u>Huntington Williams, Jr.</u>  |  | 24H. FUNERAL DIRECTOR <u>Jack Lewis</u>  |  | 24I. ADDRESS <u>2100 Eutaw Pl</u>  |  |





452

50 5555

## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

|   |  |  |  |
|---|--|--|--|
| BIRTH NO. 50-12435  |  | 2. DATE OF DEATH June 16, 1955   |  |
| 1. NAME OF DECEASED (Type or Print) Baby Bay L. Williams  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Md.<br>B. COUNTY |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland Balto, Md.<br>B. FULL NAME OF (If not in hospital or institution, give street address or location) University Hospital<br>C. CITY OR TOWN Baltimore 14-02   |  | D. STREET ADDRESS (If rural, give location) 1414 Madison Ave   |  |
| C. Length of stay in Baltimore 3 Yrs. Mos. Days   |  | 8. DATE OF BIRTH 6/13/50   |  |
| 5. SEX M  | 6. COLOR OR RACE Negr  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single   | 9. AGE (In years last birthday) 5 Months: 3 Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10B. KIND OF BUSINESS OR INDUSTRY  | 11. BIRTHPLACE (State or foreign country) Md.    |
| 12. CITIZEN OF WHAT COUNTRY?  |  | 13. FATHER'S NAME Hyson Williams   |  |
| 14. MOTHER'S MAIDEN NAME Lorraine Kemp  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)           |  |
| 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT Lorraine Williams  |  |
| 18. 762.0<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  | CAUSE OF DEATH<br>(A) Respiratory failure<br>DUE TO<br>(B) Primary atelectasis<br>DUE TO<br>(C)                    |  |
| 19A. DATE OF OPERATION 7  |  | 19B. MAJOR FINDINGS OF OPERATION   |  |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from 6-13, 1955, to 6-16, 1955, that I last saw the deceased alive on 6-16, 1955, and that death occurred at 7:30 p.m., from the causes and on the date stated above.   |  |  |  |
| 23A. SIGNATURE Ann Howard M. D.   |  | 23B. ADDRESS University Hospital   |  |
| 23C. DATE SIGNED June 16, 1955  |  |  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   | 24B. DATE  | 24C. NAME OF CEMETERY OR CREMATORY   | 24D. LOCATION (City, town, or county) (State)    |
| UNIVERSITY MEDICAL SCHOOL JUN 23 1950   |  |  |  |
| DATE RECEIVED BY LOCAL REGISTRAR JUN 23 1950  |  | REGISTRAR'S SIGNATURE Lorraine Williams, M.D.  |  |
| 25. FUNERAL DIRECTOR  |  | ADDRESS  |  |
| Commissioner of Health  |  |  |  |

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1915

254  
5556BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5556

Registered No.

|  |  |   |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|
| BIRTH NO.  |  | MARTIN  |  | McNULTY   |  | 2. DATE OF DEATH  |  | June 20, 1950   |  |
| 1. NAME OF DECEASED<br>(Type or Print)   |  | MARTIN  |  | McNULTY   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |  | A. STATE  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |  | B. FULL NAME OF (If not in hospital or institution, give street address or location)  |  | Harbor--Lancaster & E. Falls Ave                |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)          |  | Baltimore   |  |
| C. Length of stay in Baltimore   |  | Life  |  | Yrs. Mos. Days                                  |  | D. STREET ADDRESS (If rural, give location)   |  | 1916 E. Fayette Street  |  |
| 5. SEX   |  | 6. COLOR OR RACE  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) |  | 8. DATE OF BIRTH  |  | 9. AGE (In years last birthday)                                     |  |
| Male   |  | White   |  |   |  | NW. 22/1914   |  | 38  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | Bannery   |  | 11. BIRTHPLACE (State or foreign country)   |  | 12. CITIZEN OF WHAT COUNTRY?  |  |
|  |  |   |  |   |  | Balto. Md.  |  |   |  |
| 13. FATHER'S NAME  |  | Martin McNulty  |  | 14. MOTHER'S MAIDEN NAME                        |  | Delia McNicholas  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)  |  | (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.                         |  | 17. INFORMANT   |  | ADDRESS   |  |
|  |  |   |  | 218-07-6632                                     |  | Mrs. Delia McNulty Fayette  |  | 1916 E.   |  |
| 18. E 929.8  |  | I   |  | CAUSE OF DEATH                                  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  |  | (A) Drowning  |  | DUE TO  |  |   |  |   |  |
| ANTECEDENT CAUSES  |  | (B)   |  | DUE TO  |  |   |  |   |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  | (C)   |  |   |  |   |  |   |  |
| II   |  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |   |  |   |  |   |  |
| 19A. DATE OF OPERATION   |  | 19B. MAJOR FINDINGS OF OPERATION  |  |   |  | 20. AUTOPSY?  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |  | Harbor  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |  | 3/2   |  |
| 21D. TIME (Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED  |  | 21F. HOW DID INJURY OCCUR?                      |  |   |  | Ave.  |  |
| Ind: June 20, 1950   |  | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | Found drowned                                   |  |   |  |   |  |
| 22. I certify that I took charge of the remains described above, held an   |  | Autopsy   |  | thereon and from                                |  | Autopsy, Inspection or Inquiry  |  |   |  |
| the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input checked="" type="checkbox"/> . |  |   |  |   |  |   |  |   |  |
| 23A. SIGNATURE Earl L. Royer, M.D.   |  | 23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/> |  | 23C. DATE SIGNED                                |  | 6-20-50   |  |   |  |
| per: J. R. Royer   |  | M.D.  |  |   |  |   |  |   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  |  | 24B. DATE   |  | 24C. NAME OF CEMETERY OR CREMATORY              |  | 24D. LOCATION (City, town, or county)   |  | (State)   |  |
| Burial   |  | June 23/50  |  | New Cathedral                                   |  | Balto Md.   |  |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR   |  | REGISTRAR'S SIGNATURE   |  | 25. FUNERAL DIRECTOR                            |  | ADDRESS   |  |   |  |
| JUN 23 1950  |  | W. H. Williams, M.D.  |  | Philip Herwig Sons                              |  | Orleans   |  |   |  |
| VS 151   |  | N-990X  |  | 496X1   |  | 183   |  |   |  |



200

5557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

5557

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

2. DATE OF DEATH

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)  
A. STATE  
B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION

6. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

7. STREET ADDRESS (If rural, give location)

8. DATE OF BIRTH

9. AGE (in years last birthday)

10. UNDER 1 Year  
Months: Days

11. UNDER 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

19. ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  
II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

20. INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) (Minute) (Second)

21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1950, to June, 1950, that I last saw the deceased alive on June 19, 1950, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE  
M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

25. FUNERAL DIRECTOR ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

VS 150

00

E. Frank Hook

June 21, 1950

5406 Kensington Road

MD

Balto

Baltimore

28-01

5406 Kensington Road

June 2, 1881

69

69

Anterior Decorator

Dept Store Ark Co

Baltimore

N. S. A

Frank E. Hook

Fannie Sim

Yes, no or unknown

316-01-8269

Helen Hook

5406 Kensington Road

420.0

CAUSE OF DEATH

Anterior clastic heart disease

7 yrs.

II

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) (Minute) (Second)

21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1950, to June, 1950, that I last saw the deceased alive on June 19, 1950, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE  
M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

25. FUNERAL DIRECTOR ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

VS 150

312 63

931

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

U. S. GOVERNMENT  
PRINTING OFFICE  
WASHINGTON, D. C.  
1917

VALLEY



242

LUELLA H. NICHOLS

5558

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

50

5558

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Luella H. Nichols

2. DATE  
OF  
DEATH

June 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 1200 Valley Street

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION Hague for Aged

Lodge Sisters of the Poor

C. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

A.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

A.

8. DATE OF BIRTH

July 12, 1875

9. AGE (In years;  
last birthday)

77

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

At Home

10B. KIND OF BUSINESS OR  
INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Samuel A. Bussier

14. MOTHER'S MAIDEN NAME

Mary Ann Harper

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
Yes, on (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

—

17. INFORMANT

ADDRESS

Sister Mary vents - 1200 Valley St

18. 422 1 1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) ...  
DUE TO

Chronic Myocarditis

3 yrs

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) ...  
DUE TO

Arterio Sclerosis

5 yrs

(C) ...

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 10, 1930, to June 2, 1950, that I last saw the  
deceased alive on June 4, 1930, and that death occurred at 7:00 AM, from the causes and on the date stated above.

23A. SIGNATURE

E. G. Hall M.D.

23B. ADDRESS

M. D.

1631 E North Ave

23C. DATE SIGNED

6/22/50

24A. BURIAL, CREMA-  
TION, OR REMOVAL (Specify)

Burial

24B. DATE

June 24-1950

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge

24D. LOCATION (City, town, or county)

Pikesville, Maryland

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

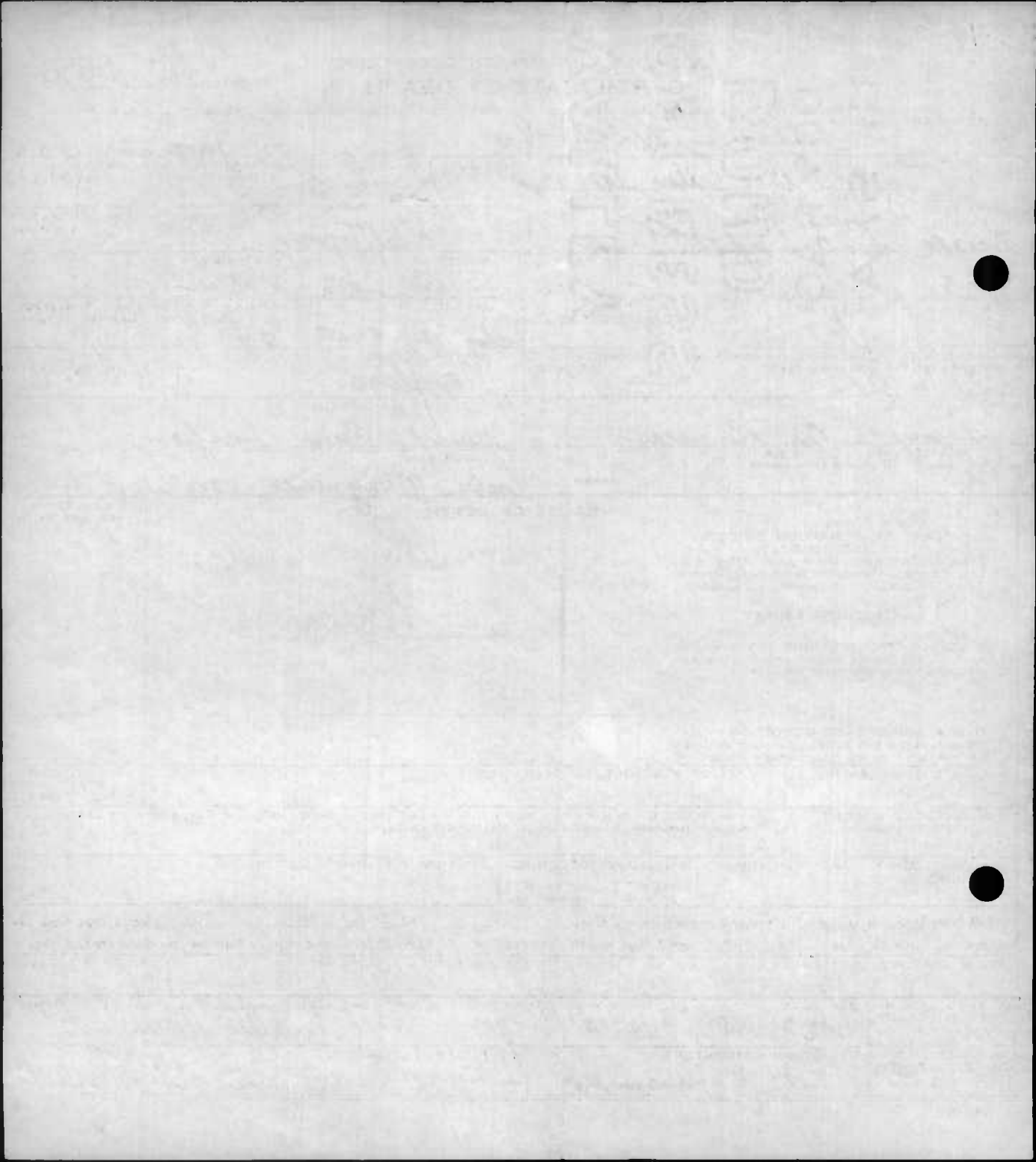
REGISTRAR'S SIGNATURE

L. W. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Burgess Funeral Home 3631 Falls Road



30  
5559

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5559  
Registered No.

|   |                                    |   |  |  |   |
|---|------------------------------------|---|--|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>JOHN H. KENNEDY</b>   |                                    |   | 2. DATE OF DEATH<br><b>June 22, 1950</b>   |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                    |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>District of Columbia</b><br>B. COUNTY <b>V-48</b> |  |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>Provident Hospital</b> |                                    |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Washington</b>  |  |   |
| c. Month of stay in Baltimore   |                                    |   | D. STREET ADDRESS (If rural, give location)  |  |   |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>colored</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH<br><b>Nov 1913</b>  | 9. AGE (In years last birthday)<br><b>36</b> | 10. Under 1 Year<br>Months Days<br><b>28 8 10</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                       |                                    |   | 11. BIRTHPLACE (State or foreign country)<br><b>Spartanburg, S.C.</b>  |  |   |
| 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Sales</b>   |                                    |   | 12. CITIZEN OF WHAT COUNTRY?   |  |   |
| 13. FATHER'S NAME<br><b>H. Kennedy</b>  |                                    |   | 14. MOTHER'S MAIDEN NAME<br><b>Hattie Dickey</b>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)                               |                                    |   | 16. SOCIAL SECURITY NO.  |  |   |
| 17. INFORMANT<br><b>Mrs. E. Means</b>   |                                    |   | ADDRESS<br><b>1532 Hawthorne</b>   |  |   |

|  |                                  |
|--|----------------------------------|
| 18. <b>463 X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Pulmonary embolism</b><br>DUE TO <b>thrombophlebitis of peripheral vessels</b> | INTERVAL BETWEEN ONSET AND DEATH |
| I<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B)<br>(C)  |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                                  |

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 19A. DATE OF OPERATION<br><b>June 22, 1950</b>  |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that I took charge of the remains described above, held an <u>autopsy</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |  |  |  |   |  |
| 23A. SIGNATURE<br><b>Stanley H. Dineen</b>  |  | 23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                                      |  | 23C. DATE SIGNED<br><b>June 22, 1950</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   |  | 24B. DATE<br><b>June 24, 1950</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Hopewell</b>                               |  |
| 24D. LOCATION (City, town, or county)   |  | 24E. FUNERAL DIRECTOR<br><b>Joseph C. Run</b>  |  | 24F. ADDRESS<br><b>1200 meadow</b>  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 23 1950</b>  |  | REGISTRAR'S SIGNATURE<br><b>Washington Williams</b>  |  | 25. FUNERAL DIRECTOR<br><b>Joseph C. Run</b>  |  |
| VS 151  |  | 98809  |  | 100B ✓  |  |

PLATTSMOUTH CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

PLATTSMOUTH, IOWA

|                        |  |                        |  |                       |  |
|------------------------|--|------------------------|--|-----------------------|--|
| Name of Deceased       |  | Sex                    |  | Age                   |  |
| Date of Birth          |  | Date of Death          |  | Place of Death        |  |
| Cause of Death         |  | Died at                |  | Buried at             |  |
| Physician              |  | Funeral Home           |  | Burial Place          |  |
| Signature of Physician |  | Signature of Registrar |  | Signature of Minister |  |
| Date                   |  | Time                   |  | Place                 |  |

*George C. Davis*

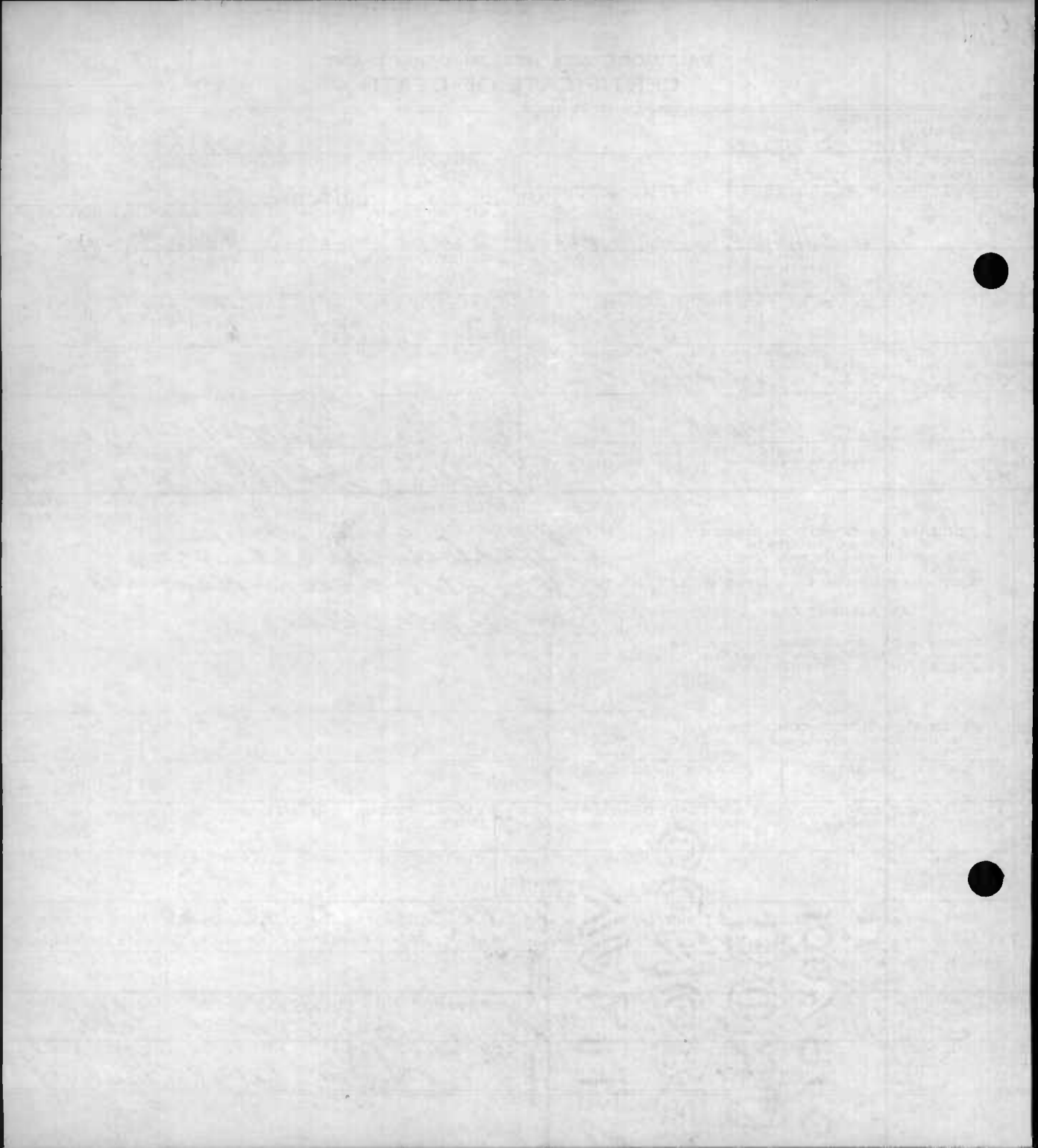
341  
5560

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5560

|  |   |   |  |  |                               |
|--|---|---|--|--|-------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Grace Stalfort</i>   |   |   | 2. DATE OF DEATH <i>6-22-50</i>  |  |                               |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>md</i> B. COUNTY <i>Baltimore</i> |  |                               |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>South Baltimore General Hospital</i>   |   |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>2569 Edmondson Ave 20-02</i>                        |  |                               |
| C. Length of stay in Baltimore<br>Yrs. Mos. Days   |   |   | D. STREET ADDRESS (If rural, give location)  |  |                               |
| 5. SEX<br><i>F</i>   | 6. COLOR OR RACE<br><i>W</i>                          | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>W</i>   | 8. DATE OF BIRTH<br><i>July 27, 1883</i>   | 9. AGE (In years last birthday)<br><i>66</i> | 10. Under 1 Year Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>  |   |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>at home</i>  |  |                               |
| 11. BIRTHPLACE (State or foreign country)  |   |   | 12. CITIZEN OF WHAT COUNTRY?   |  |                               |
| 13. FATHER'S NAME<br><i>George Lewis Amend</i>   |   |   | 14. MOTHER'S MAIDEN NAME<br><i>Cecilia Edmeyer</i>   |  |                               |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>no</i>  |   |   | 16. SOCIAL SECURITY NO.<br><i>Robert E. Stalfort, 2569</i>   |  |                               |
| 18. <i>420.0</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |   |   | CAUSE OF DEATH<br>(A) <i>Myocardial Infarction</i><br>DUE TO <i>Chronic heart disease</i><br>(B) <i>heart failure</i><br>DUE TO<br>(C) |  |                               |
| 19A. DATE OF OPERATION <i>0</i>  |   |   | 19B. MAJOR FINDINGS OF OPERATION   |  |                               |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |   | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |                               |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   |   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |                               |
| 22. I hereby certify that I attended the deceased from <i>6-18-50</i> , 19 <i>50</i> to <i>6-22-50</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>6-17-50</i> , 19 <i>50</i> and that death occurred at <i>6-20pm</i> , from the causes and on the date stated above.   |   |   |  |  |                               |
| 23A. SIGNATURE<br><i>[Signature]</i>   |   |   | 23B. ADDRESS   |  | 23C. DATE SIGNED              |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   | 24B. DATE<br><i>6/26/50</i>                           | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Pen Cathedral</i>  | 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore Md</i>   |  |                               |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUN 23 1950</i>   | REGISTRAR'S SIGNATURE<br><i>Wm. J. Williams, M.D.</i> | 25. FUNERAL DIRECTOR<br><i>[Signature]</i>  |  | ADDRESS<br><i>1217 St Paul St</i>            |                               |

MEDICAL CERTIFICATION



32

0 5561

BIRTH NO.

5561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

50 5561

1. NAME OF DECEASED  
(Type or Print)

Thomas Fletcher

2. DATE OF DEATH

June 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md. B. COUNTY City

5. FULL NAME OF HOSPITAL OR INSTITUTION

Provident Hosp.

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 14-02

7. Length of stay in Baltimore

25

8. STREET ADDRESS (If rural, give location)

538- Mosker st.

9. SEX

Male

10. COLOR OR RACE

Colored

11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

12. DATE OF BIRTH

? ? 1860

13. AGE (In years, last birthday)

90

14. If Under 1 Year Months: Days

15. If Under 24 Hours Hours: Min.

16. USUAL OCCUPATION (Give kind of work followed during most of working life, even if retired)

junk man

17. KIND OF BUSINESS OR INDUSTRY

odd jobs

18. BIRTHPLACE (State or foreign country)

ga.

19. CITIZEN OF (What country?)

U.S.A.

20. FATHER'S NAME

unknown

21. MOTHER'S MAIDEN NAME

unknown

22. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

no

23. SOCIAL SECURITY NO.

none

24. INFORMANT

Elizabeth White - Mosker st.

25. CAUSE OF DEATH

446 X

26. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia

27. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Nephrosclerosis

28. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Essential hypertension

29. INTERVAL BETWEEN ONSET AND DEATH

Undet.

30. DATE OF OPERATION

0

31. MAJOR FINDINGS OF OPERATION

32. AUTOPSY?

YES ☐ NO ☒

33. ACCIDENT, SUICIDE, HOMICIDE (Specify)

34. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

35. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

36. TIME (Month) (Day) (Year) (Hour)

37. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

38. HOW DID INJURY OCCUR?

39. I hereby certify that I attended the deceased from 5-11-1919, to June 19, 1950, that I last saw the deceased alive on June 19, 1950, and that death occurred at 11:30 a.m., from the causes and on the date stated above.

40. SIGNATURE

John C. [Signature]

41. ADDRESS

1101 [Address]

42. DATE SIGNED

Jan 23, 1950

43. BURIAL, CREMATION, REMOVAL (Specify)

Burial

44. DATE

6/24/50

45. NAME OF CEMETERY OR CREMATORY

Mt. Calvary

46. LOCATION (City, town, or county) (State)

Carm Hill Md

47. DATE RECEIVED BY LOCAL REGISTRAR

JUN 23 1950

48. REGISTRAR'S SIGNATURE

Washington Williams, M.D.

49. FUNERAL DIRECTOR

Adolphus Halstead

50. ADDRESS

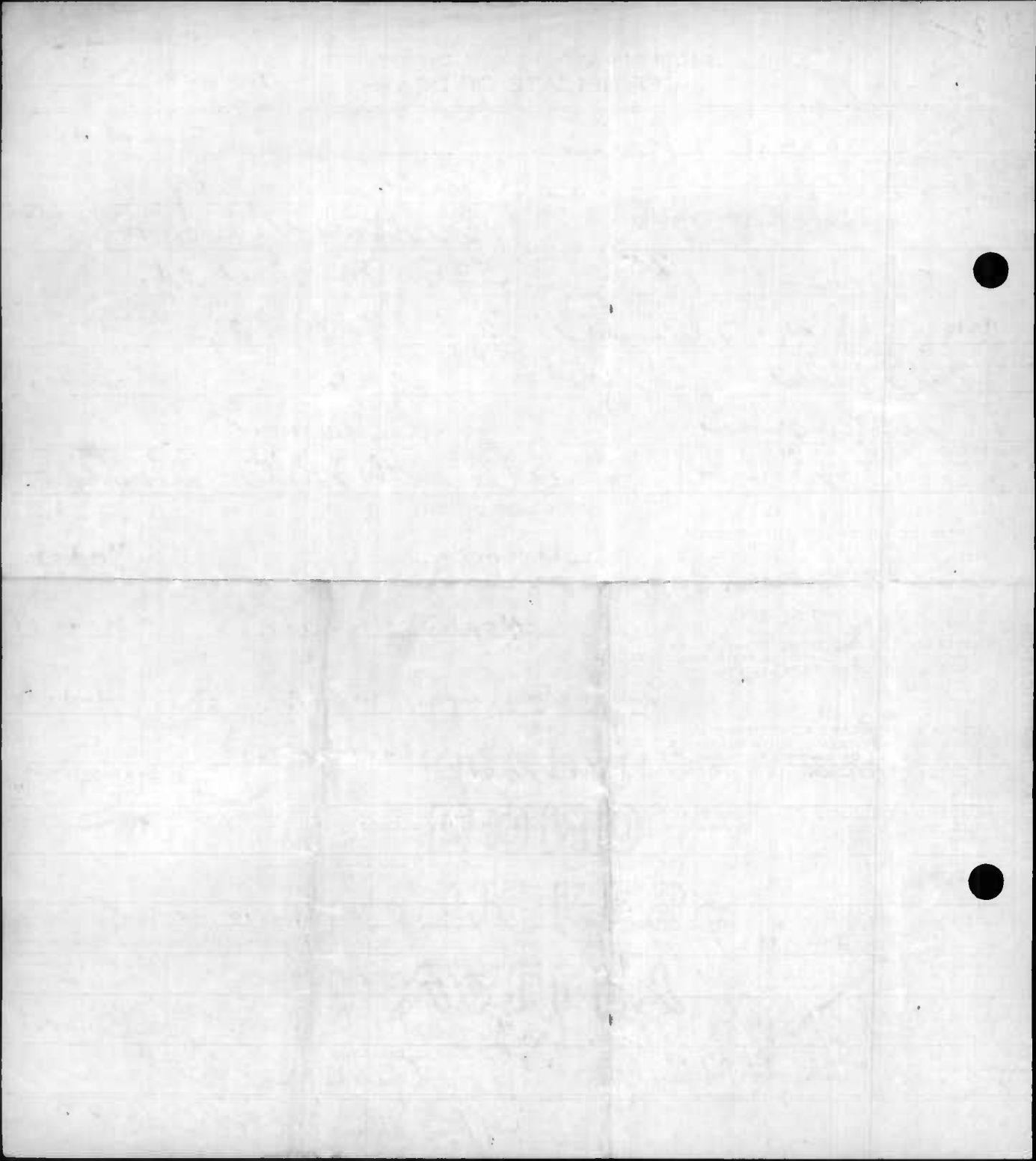
915- [Address]

VS 150

131a

MEDICAL CERTIFICATION





52

5582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 5562

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

OLIVE D. ROBINSON

2. DATE OF DEATH

June 22, 1950

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION  
(If not in hospital or institution, give street address or location)

1904 Park Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE  
Md.

C. CITY OR TOWN  
(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1904 Park Ave.

C. Length of stay in Baltimore  
Yrs.  
Mos.  
Days

5. SEX  
female

6. COLOR OR RACE  
white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
single

8. DATE OF BIRTH  
Jan. 25, 1891

9. AGE (in years last birthday)  
59

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
Dep. Clerk

10B. KIND OF BUSINESS OR INDUSTRY  
U. S. Distr. Court

11. BIRTHPLACE (State or foreign country)  
Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME  
Joseph J. Robinson

14. MOTHER'S MAIDEN NAME  
Miriam J. Spamer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
no

16. SOCIAL SECURITY NO.  
no

17. INFORMANT  
Mr. H. S. Robinson

ADDRESS  
Monkton, Md.

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
442X,  
Hypertensive cardio-vascular renal disease

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION  
0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1939 to 6-22, 1950, that I last saw the deceased alive on 6-21, 1950, and that death occurred at 8:30 A.m., from the causes and on the date stated above.

23A. SIGNATURE  
H. L. Ewald Jr.

23B. ADDRESS  
36 Park Court

23C. DATE SIGNED  
6-23-50

24A. BURIAL, CREMATION, REMOVAL (Specify)  
Burial

24B. DATE  
6/24/50

24C. NAME OF CEMETERY OR CREMATORY  
Rooky Rest

24D. LOCATION (City, town, or county) (State)  
Balto. Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR  
JUN 23 1950

REGISTRAR'S SIGNATURE  
Wm. J. Williams, M.D.

25. FUNERAL DIRECTOR  
Wm. J. Williams, M.D.

ADDRESS  
1312 Md

VS 150

1189A

1312

52

5582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 5562

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

OLIVE D. ROBINSON

2. DATE OF DEATH

June 22, 1950

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION  
(If not in hospital or institution, give street address or location)

1904 Park Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE  
Md.

C. CITY OR TOWN  
(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1904 Park Ave.

C. Length of stay in Baltimore  
Yrs.  
Mos.  
Days

5. SEX  
female

6. COLOR OR RACE  
white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
single

8. DATE OF BIRTH  
Jan. 25, 1891

9. AGE (in years last birthday)  
59

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
Dep. Clerk

10B. KIND OF BUSINESS OR INDUSTRY  
U. S. Distr. Court

11. BIRTHPLACE (State or foreign country)  
Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME  
Joseph J. Robinson

14. MOTHER'S MAIDEN NAME  
Miriam J. Spamer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
no

16. SOCIAL SECURITY NO.  
no

17. INFORMANT  
Mr. H. S. Robinson

ADDRESS  
Monkton, Md.

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
442X,  
Hypertensive cardio-vascular renal disease

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION  
0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1939 to 6-22, 1950, that I last saw the deceased alive on 6-21, 1950, and that death occurred at 8:30 A.m., from the causes and on the date stated above.

23A. SIGNATURE  
H. L. Ewald Jr.

23B. ADDRESS  
36 Park Court

23C. DATE SIGNED  
6-23-50

24A. BURIAL, CREMATION, REMOVAL (Specify)  
Burial

24B. DATE  
6/24/50

24C. NAME OF CEMETERY OR CREMATORY  
Rooky Rest

24D. LOCATION (City, town, or county) (State)  
Balto. Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR  
JUN 23 1950

REGISTRAR'S SIGNATURE  
Wm. J. Williams, M.D.

25. FUNERAL DIRECTOR  
Wm. J. Williams, M.D.

ADDRESS  
1312 Md

VS 150

1189A

1312

RECEIVED

RECEIVED  
FBI  
JAN 10 1964

W-452  
50 5563BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5563

Registered No.

|  |                             |  |                                    |   |   |
|--|-----------------------------|--|------------------------------------|---|---|
| BIRTH NO. 50 5563  |                             | 1. NAME OF DECEASED<br>(Type or Print) EMMA WILLIAMS   |                                    | 2. DATE OF DEATH June 22, 1950  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY |                                    |   |   |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br>Ba. Hil. Ba Convalescence Home  |                             | 6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 27-15                      |                                    |   |   |
| c. Length of stay in Baltimore   |                             | D. STREET ADDRESS (If rural, give location)<br>2101 Cold Spring Lane   |                                    |   |   |
| 5. SEX<br>Female   | 6. COLOR OR RACE<br>Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Widow   | 8. DATE OF BIRTH<br>Sept. 19, 1869 | 9. AGE (In years last birthday)<br>80   | 10. Under 1 Year<br>Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife   |                             | 10B. KIND OF BUSINESS OR INDUSTRY<br>None  |                                    | 11. BIRTHPLACE (State or foreign country)<br>Maryland                               |   |
| 12. CITIZEN OF WHAT COUNTRY?<br>Maryland   |                             | 13. FATHER'S NAME<br>Unknown   |                                    | 14. MOTHER'S MAIDEN NAME<br>Unknown   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br>Yes, no or unknown  |                             | 16. SOCIAL SECURITY NO.  |                                    | 17. INFORMANT<br>Mrs. Elizabeth Telley Cold Spring Lane                             |   |
| 18. 442X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br>(A) Hypertensive - Cardiac -<br>Renal Decm<br>(B) DUE TO<br>(C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                             | INTERVAL BETWEEN ONSET AND DEATH   |                                    |   |   |
| 19A. DATE OF OPERATION 0   |                             | 19B. MAJOR FINDINGS OF OPERATION   |                                    | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)<br>no   |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>no                       |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>no      |   |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>no  |                             | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/><br>no         |                                    | 21F. HOW DID INJURY OCCUR?<br>no  |   |
| 22. I hereby certify that I attended the deceased from 1/7/1950, to 6/22/1950, that I last saw the deceased alive on 6/21/1950, and that death occurred at 8 A.M., from the causes and on the date stated above.   |                             |  |                                    |   |   |
| 23A. SIGNATURE<br>W. Williams  |                             | 23B. ADDRESS<br>1300 N. Fremont Ave.   |                                    | 23C. DATE SIGNED<br>6/22/50   |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |                             | 24B. DATE<br>6-23-1950   |                                    | 24C. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn                                    |   |
| 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Md.  |                             | 24E. FUNERAL DIRECTOR<br>Halland Funeral Home  |                                    | 24F. ADDRESS<br>1651 Quind Hill Ave.  |   |
| DATE RECEIVED BY LOCAL REGISTRAR   |                             | REGISTRAR'S SIGNATURE<br>Huntington Williams, M.D.   |                                    | 25. FUNERAL DIRECTOR<br>Halland Funeral Home  |   |

Apprentice - Books  
and Papers

1/22

1000 x 1000 on 1/22/20

W. J. J. J.

H-662

50 5564

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5564

Registered No.

|   |                                  |  |  |  |  |
|---|----------------------------------|--|--|--|--|
| BIRTH NO.   |                                  | 1. NAME OF DECEASED<br>(Type or Print) <b>John Grigorchuk - HREHORCHUK</b>   |  | 2. DATE OF DEATH<br><b>6/20/50</b>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>Baltimore, Maryland</b>  |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |  |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>South Baltimore General Hospital</b>  |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)<br><b>Baltimore</b> <b>25-05</b>                 |  |  |  |
| C. Length of stay in Baltimore  |                                  | D. STREET ADDRESS (If rural, give location)<br><b>5022 Pennington Avenue</b>   |  |  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Single</b>   |  | 8. DATE OF BIRTH<br><b>MAY 11-1880</b>   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>LABORER</b>   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>FACTORY</b>  |  | 9. AGE (In years last birthday) <b>69</b><br>If Under 1 Year: Months: Days<br>If Under 24 Hours: Hours: Min. |  |
| 13. FATHER'S NAME<br><b>A. GRIGORCHUK</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>NOT KNOW</b>  |  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)   |                                  | 16. SOCIAL SECURITY NO.<br><b>219-16-6779</b>  |  | 17. INFORMANT ADDRESS<br><b>MRS. F. GUMN 5022 PENNINGTON</b>   |  |
| 18. <b>420.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br>(A) <b>Myocardial Infarction</b><br>DUE TO<br>(B) <b>Massive Myocardial Infarction</b><br>DUE TO<br>(C) <b>Coronary Sclerosis</b><br>INTERVAL BETWEEN ONSET AND DEATH |                                  | 19. DATE OF OPERATION<br><b>4</b>  |  |  |  |
| 19A. DATE OF OPERATION  |                                  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                                      |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                     |  |
| 21D. TIME (Month) (Day) (Year) (Hour) (Minute)<br>INJURY  |                                  | 21E. INJURY OCCURRED<br>WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK                      |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <b>6/12/50</b> , 19__, to <b>6/20/50</b> , 19__, that I last saw the deceased alive on <b>6/20/50</b> , 19__, and that death occurred at <b>9:25 A.M.</b> , from the causes and on the date stated above.  |                                  |  |  |  |  |
| 23A. SIGNATURE<br><b>John P. Sarno</b>  |                                  | 23B. ADDRESS<br><b>So. Balt. Gen. Hosp.</b>  |  | 23C. DATE SIGNED<br><b>6/20/50</b>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 24B. DATE<br><b>June 23-50</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Holy Trinity Russian</b>  |  |
| 24D. LOCATION (City, town, or county)<br><b>Elkridge Md</b>   |                                  | 24E. LOCATION (State)<br><b>Md</b>   |  |  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 23 1950</b>  |                                  | REGISTRAR'S SIGNATURE<br><b>William H. Williams, M.D.</b>  |  | 25. FUNERAL DIRECTOR<br><b>J. A. Grebhanek Jr</b>  |  |
| ADDRESS<br><b>1905 E. Pratt</b>   |                                  | ADDRESS  |  |  |  |

PD 1881-11 YAM



512  
50 5565BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5565  
Registered No. \_\_\_\_\_

|   |                           |  |   |  |                                |
|---|---------------------------|--|---|--|--------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print)  |                           | ANNIE R. THOMPSON  |   | 2. DATE OF DEATH<br>June 21, 1950  |                                |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                           | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE Md.<br>B. COUNTY |   |  |                                |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>318 E. 25th St.  |                           | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 12-03                    |   |  |                                |
| C. Length of stay in Baltimore  |                           | D. STREET ADDRESS (If rural, give location)<br>318 E. 25th St.   |   |  |                                |
| 5. SEX<br>female  | 6. COLOR OR RACE<br>white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>widow   | 8. DATE OF BIRTH<br>Jan. 11, 1855                     | 9. AGE (In years last birthday)<br>95  | H Under 1 Year<br>Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>housewife  |                           | 10B. KIND OF BUSINESS OR INDUSTRY<br>at home   | 11. BIRTHPLACE (State or foreign country)<br>Maryland |  | 12. CITIZEN OF WHAT COUNTRY?   |
| 13. FATHER'S NAME<br>Joseph Hughes  |                           | 14. MOTHER'S MAIDEN NAME<br>Mary Jane Evans  |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) |                                |
| 16. SOCIAL SECURITY NO.   |                           | 17. INFORMANT ADDRESS<br>Mr. T. Lyde Mason, Jr. 208 E. Joppa Rd. Towson, Md.                                       |   |  |                                |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>422.1<br>CAUSE OF DEATH<br>Myocardial Failure<br>DUE TO<br>Generalized Atherosclerosis<br>INTERVAL BETWEEN ONSET AND DEATH<br>3 months -<br>30 yrs - |                           | 19. DATE OF OPERATION 0  |   |  |                                |
| 19A. DATE OF OPERATION 0  |                           | 19B. MAJOR FINDINGS OF OPERATION   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                 |                                |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                           | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                          |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                 |                                |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>INJURY   |                           | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>          |   | 21F. HOW DID INJURY OCCUR?   |                                |
| 22. I hereby certify that I attended the deceased from 1944 to 4/21, 1950, that I last saw the deceased alive on 4/21, 1950, and that death occurred at 11:20 p. m., from the causes and on the date stated above.  |                           |  |   |  |                                |
| 23A. SIGNATURE<br>Dorothy L. Warrick  |                           | 23B. ADDRESS<br>3900 Alameda Blvd.<br>M. D.  |   | 23C. DATE SIGNED<br>6/23/50  |                                |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                           | 24B. DATE<br>6/24/50   |   | 24C. NAME OF CEMETERY OR CREMATORY<br>Greenmount Cem.  |                                |
| 24D. LOCATION (City, town, or county) (State)<br>Balto., Md.  |                           | 25. FUNERAL DIRECTOR<br>J. T. Dickerson & Sons<br>937 Balto. Md.   |   |  |                                |
| DATE RECEIVED BY LOCAL REGISTRAR<br>JUN 23 1950   |                           | REGISTRAR'S SIGNATURE<br>R. W. Williams, M.D.  |   | ADDRESS  |                                |

CERTIFICATE OF DEATH

STATE OF NEW YORK

County of \_\_\_\_\_

City of \_\_\_\_\_

State of New York

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BAER

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5566

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Baer, Mrs. Annie C.</b>                                       |                                  | 2. DATE OF DEATH <b>June 23, 1950</b>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>md</b><br>B. COUNTY <b>Baltimore</b> |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Church Home &amp; Hospo.</b>                              |                                  | C. CITY OR TOWN (If outside corporate limits, write KURAL and give township)<br><b>Baltimore 27-12</b>                                    |  |
| C. Month of stay in Baltimore <b>Life</b>   |                                  | D. STREET ADDRESS (If rural, give location)<br><b>426 E. Lake Ave.</b>  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b>   | 8. DATE OF BIRTH<br><b>Apr 6, 1867</b> |
| 9. AGE (In years, Months, Days)<br><b>82</b>  |                                  | 10. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)             |                                  | 10B. KIND OF BUSINESS OR INDUSTRY   |  |
| 13. FATHER'S NAME<br><b>Thompson, Mr. James</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Reynolds, Margaret</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) |                                  | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>Mrs. M. G. Tull</b>   |                                  | ADDRESS<br><b>426 E Lake</b>  |  |

|   |                                      |                                |   |
|---|--------------------------------------|--------------------------------|---|
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | CAUSE OF DEATH                       |                                | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b> |
|   | (A) DUE TO                           | <b>Myocardial infarction</b>   |   |
|   | (B) DUE TO                           | <b>Myocardial degeneration</b> |   |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  | (C) <b>Coronary arteriosclerosis</b> |                                | <b>Many years</b>                                 |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                                      |                                |   |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 19A. DATE OF OPERATION <b>9</b>  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>June 22, 1950</b> , to <b>June 23, 1950</b> , that I last saw the deceased alive on <b>June 23, 1950</b> , and that death occurred at <b>3:30 A.M.</b> , from the causes and on the date stated above. |  |   |  |   |  |
| 23. SIGNATURE<br><b>R. Arnold S. Seaton</b>  |  | M. D.   |  | 23B. ADDRESS<br><b>Church Home Hosp.</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  |  | 24B. DATE<br><b>6/25/50</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Slate Ridge Cem.</b>                       |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Delta, Pa.</b>   |  | 24E. DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 23 1950</b>   |  | 24F. REGISTRAR'S SIGNATURE<br><b>Washington Williams, M.D.</b>                      |  |
| 24G. FUNERAL DIRECTOR<br><b>Wm. J. Dickner &amp; Sons</b>  |  | ADDRESS<br><b>Baltimore</b>   |  | 24H. DATE SIGNED<br><b>June 23, 1950</b>  |  |

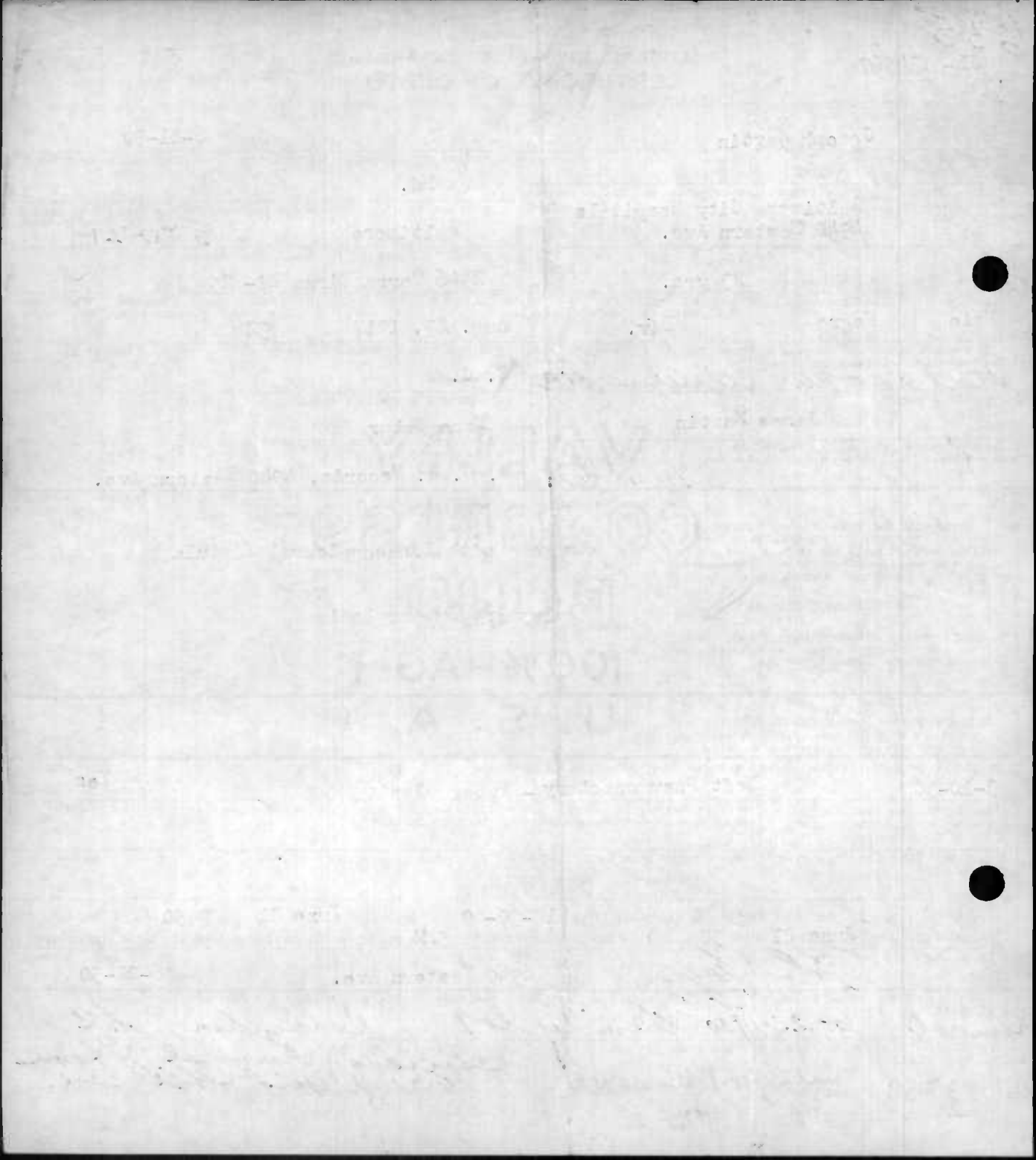
STATE OF NEW YORK  
CERTIFICATE OF DEATH

On this 10th day of June 1922  
I, the undersigned, Registrar of the County of Albany,  
do hereby certify that the within and foregoing is a true and correct  
copy of the original of the death record of the deceased person  
named therein, as the same appears from the records of the  
County of Albany, New York, in the year 1922.

At Albany, New York, this 10th day of June 1922.

\_\_\_\_\_  
Registrar of the County of Albany







462

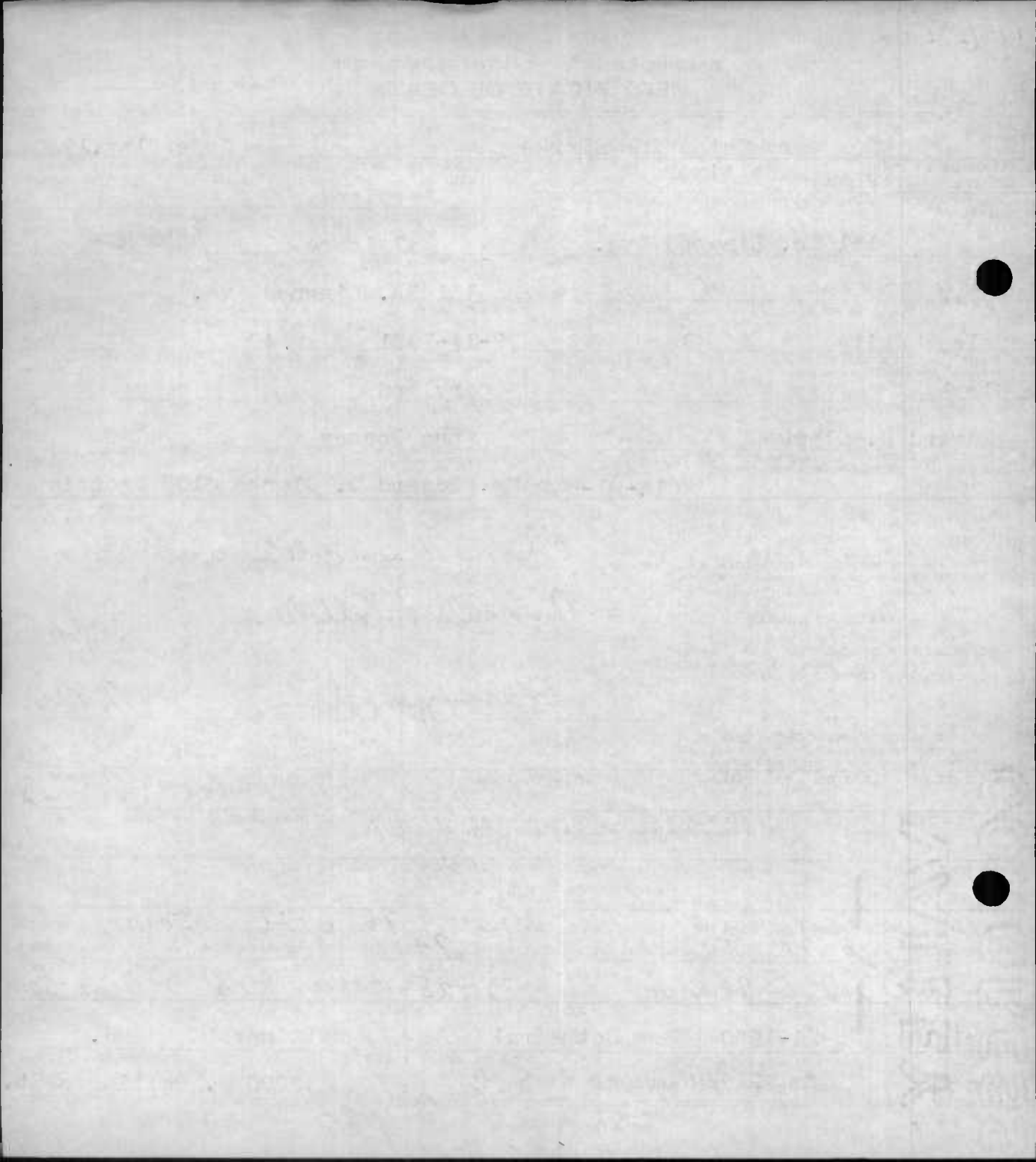
BIRTH NO. 5568

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5568

|   |                                  |   |                                      |   |   |   |  |
|---|----------------------------------|---|--------------------------------------|---|---|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Mary Catherine Clarke</b>   |                                  |   |                                      | 2. DATE OF DEATH <b>June 21st. 1950</b>   |   |   |  |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b> <b>Baltimore</b>   |                                  |   |                                      | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY |   |   |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>131 So. Linwood Ave.</b>   |                                  |   |                                      | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>1-02</b>                |   |   |  |
| c. Length of stay in Baltimore <b>Life</b> Yrs. Mos. Days   |                                  |   |                                      | D. STREET ADDRESS (If rural, give location)<br><b>131 So. Linwood Ave.</b>  |   |   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Single</b>  | 8. DATE OF BIRTH<br><b>9-14-1901</b> |   | 9. AGE (In years last birthday)<br><b>48 49</b> | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>          |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clerk</b>   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Office (Govt.)</b>  |                                      | 12. CITIZEN OF WHAT COUNTRY?  |   | 14. MOTHER'S MAIDEN NAME<br><b>Anna Dorsey</b>                        |  |
| 13. FATHER'S NAME<br><b>Edward M. Clarke</b>  |                                  |   |                                      | 16. SOCIAL SECURITY NO.<br><b>212-01-6396</b>   |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><input checked="" type="checkbox"/>  |                                  |   |                                      | 17. INFORMANT ADDRESS<br><b>Mr. Edward O. Clarke 3108 Sequoia Ave.</b>  |   |   |  |
| 18. <b>422.2</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Chronic Myocarditis with Atrial Fibrillation</b><br>DUE TO<br><b>Decompensation</b> |                                  |   |                                      | INTERVAL BETWEEN ONSET AND DEATH<br><b>yes</b><br><b>3 years</b><br><b>2 mos.</b>   |   |   |  |
| 19A. DATE OF OPERATION <b>0</b>   |                                  |   |                                      | 19B. MAJOR FINDINGS OF OPERATION  |   |   |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |                                      | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>INJURY   |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |                                      | 21F. HOW DID INJURY OCCUR?  |   |   |  |
| 22. I hereby certify that I attended the deceased from <b>Dec. 1946</b> <b>6-24</b> , 1950 that I last saw the deceased alive on <b>6-20</b> , 1950, and that death occurred at <b>7A m.</b> , from the causes and on the date stated above.  |                                  |   |                                      | 23A. SIGNATURE<br><b>William L. Pearson</b> M. D.   |   |   |  |
| 23B. ADDRESS<br><b>3025 Belair Road</b>   |                                  |   |                                      | 23C. DATE SIGNED<br><b>6-22-50</b>  |   |   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 24B. DATE<br><b>6-24-1950</b>   |                                      | 24C. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>  |   | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Md.</b> |  |
| DATE RECEIVED BY<br>LOCAL REGISTRAR<br><b>JUN 23 1950</b>   |                                  | REGISTRAR'S SIGNATURE<br><b>Thurston Williams, M.D.</b>   |                                      | 25. FUNERAL DIRECTOR ADDRESS<br><b>John A. Moran 3000 E. Baltimore St.</b><br><b>H&amp;R.</b>                               |   |   |  |





524  
5569

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5569  
Registered No.

|   |  |  |  |
|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Mr. Edward Martin Hanzely</b>  |  | 2. DATE OF DEATH<br><b>June 21, 1950</b>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>Baltimore</b>  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION<br><b>St. Joseph's Hospital</b> |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>                               |  |
| D. STREET ADDRESS (If rural, give location)<br><b>3816 Kimble Rd.</b>   |  | E. DATE OF BIRTH<br><b>6-16-1914</b>   |  |
| F. AGE (In years last birthday)<br><b>36</b>  |  | G. CITIZEN OF WHAT COUNTRY?<br><b>Baltimore, Maryland</b>  |  |
| H. MOTHER'S MAIDEN NAME<br><b>Julia K. Brier</b>  |  | I. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>   |  |
| J. FATHER'S NAME<br><b>Martiny Hanzely</b>  |  | K. MOTHER'S MAIDEN NAME<br><b>Julia K. Brier</b>   |  |
| L. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(If yes, give war or dates of service)<br><b>Yes, no or unknown</b>                              |  | M. SOCIAL SECURITY NO.<br><b>213-01-0495</b>   |  |
| N. INFORMANT<br><b>Mrs. Catherine D. Hanzely</b>  |  | O. ADDRESS<br><b>3816 Kimble Rd.</b>   |  |

|  |  |                                  |  |
|--|--|----------------------------------|--|
| 18. CAUSE OF DEATH<br><b>Rheumatic heart disease</b>   |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>(A) DUE TO</b> |  |                                  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>(B) DUE TO</b>  |  |                                  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>(C)</b>  |  |                                  |  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 19A. DATE OF OPERATION<br><b>6/21/50</b>  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>6/21/1950</b> to <b>6/21/1950</b> that I last saw the deceased alive on <b>6/21/1950</b> , and that death occurred at <b>1:20 PM.</b> , from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE<br><b>Thaddeus Sawinski</b>  |  | 23B. ADDRESS<br><b>1400 N. Caroline Street</b>  |  | 23C. DATE SIGNED<br><b>6/21/50</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>6-24-1950</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross</b>                             |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>A.A.Co.</b>   |  | 25. FUNERAL DIRECTOR<br><b>John H. Moran</b>  |  |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 23 1950</b>  |  | REGISTRAR'S SIGNATURE<br><b>Thaddeus Sawinski</b>   |  | ADDRESS<br><b>3000 E. Baltimore St.</b>   |  |

VS 150  
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CERTIFICATE OF DEATH

|                        |  |                        |  |
|------------------------|--|------------------------|--|
| Name of Deceased       |  | Date of Death          |  |
| Place of Birth         |  | Date of Birth          |  |
| Sex                    |  | Race                   |  |
| Marital Status         |  | Cause of Death         |  |
| Occupation             |  | Place of Death         |  |
| Signature of Physician |  | Signature of Registrar |  |
| Date of Certificate    |  | Place of Issuance      |  |

# CERTIFICATE CORRECTED

8-10-50

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 50 5570

5570

BIRTH NO.

|   |                                  |   |  |  |   |
|---|----------------------------------|---|--|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Dr. Edward Dorsey Ellis</b>   |                                  |   | 2. DATE OF DEATH <b>June 22, 1950</b>  |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>Baltimore</b> none |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>11 Club Road</b> |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>27-14</b>  |  |   |
| C. Length of stay in Baltimore<br><b>2 Yrs. Mos. Days</b>   |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>11 Club Road</b>   |  |   |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>married</b> | 8. DATE OF BIRTH<br><b>11 - 22 - 68</b>  |  | 9. AGE (In years last birthday)<br><b>81</b>                            |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>physician</b>                     |                                  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>general medicine</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b> |
| 13. FATHER'S NAME<br><b>John E. Ellis</b>   |                                  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>Yes</b>   |                                  |   | 16. SOCIAL SECURITY NO.<br><b>May 1917 to March 1919</b>   |  |   |
| 17. INFORMANT<br><b>James C. Taylor - 323 Taplow Road</b>   |                                  |   | ADDRESS  |  |   |

|  |  |   |
|--|--|---|
| 18. <b>442 X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic Cardio Vascular Renal Disease</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Prior to 13 March 1949</b> |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Senile Dementia - Broncho-pneumonia - Uremia - Anamniotic</b>   |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>Dysphagia - (Cerebral Thrombosis OR Esophagosa Carcinoma)</b>  |  | <b>3 weeks</b>  |

|   |   |  |  |   |
|---|---|--|--|---|
| 19A. DATE OF OPERATION <b>0</b>   |   | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |   |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |   |
| 22. I hereby certify that I attended the deceased from <b>March 13, 1949</b> , to <b>22 June, 1950</b> , that I last saw the deceased alive on <b>22 June, 1950</b> , and that death occurred at <b>12:30 p. m.</b> , from the causes and on the date stated above. |   |  |  |   |
| 23A. SIGNATURE<br><b>W. K. Waller</b>   |   | 23B. ADDRESS<br><b>512 Cathedral St.</b>                                 |  | 23C. DATE SIGNED  |

|  |                             |  |   |
|--|-----------------------------|--|---|
| 24A. BURIAL / CREMATION, REMOVAL (Specify)<br><b>cremation</b> | 24B. DATE<br><b>6/24/50</b> | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>   | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b> |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 23 1950</b>         |                             | 25. FUNERAL DIRECTOR ADDRESS<br><b>John O. Mitchell &amp; Sons, Inc. - 1900 Eutaw Pl.</b><br><b>W. K. Waller</b> |   |
| Dr. W. K. WALLER - after 2 PM                                  |                             |  |   |

131a

DECLARATION OF BANKRUPTCY

IN SENATE, January 1, 1900

Subscribed and sworn to before me this 1st day of January, 1900

Notary Public

My Commission Expires

11 - 12 - 00

Notary Public

My Commission Expires

11 - 12 - 00

632

50 5571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 5571

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

2. DATE OF DEATH

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE  
B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

7. D. STREET ADDRESS (If rural, give location)

8. DATE OF BIRTH

9. AGE (In years last birthday)

10. UNDER 1 Year  
Months Days

11. UNDER 24 Hours  
Hours Min.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

18. ADDRESS

19. DATE OF OPERATION

20. AUTOPSY?  
YES NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED  
WHILE AT WORK NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from to , 19 , that I last saw the deceased alive on , 19 , and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

25. FUNERAL DIRECTOR

ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

VS 153 1950

33P41

937



VALLEY  
CONGREGES



50

5572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

5572

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HARRY A. HEANY

2. DATE OF DEATH

6/22/50.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland, B. COUNTY Baltimore.

5. FULL NAME OF HOSPITAL OR INSTITUTION

Chesapeake House & Hospital.

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 15-08A

7. D. STREET ADDRESS (If rural, give location)

2811 Allendale Rd.

8. DATE OF BIRTH

11/29/1872

9. AGE (In years last birthday)

77 yrs.

10. BIRTHPLACE (State or foreign country)

Maryland.

11. CITIZEN OF WHAT COUNTRY?

USA

12. MOTHER'S MAIDEN NAME

Catherine P. Debring

13. FATHER'S NAME

John P. Heany (HEANY)

14. SOCIAL SECURITY NO.

561.4

15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no or unknown)

(If yes, give war or dates of service)

16. INFORMANT ADDRESS

Charles M. Heany K. of C. Club

17. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary edema.

18. ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Epigastric Hernia & intestinal obstruction

19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Uremia

20. INTERVAL BETWEEN ONSET AND DEATH

3 days

21. DATE OF OPERATION

6/19/50

22. MAJOR FINDINGS OF OPERATION

Epigastric hernia.

23. AUTOPSY?

YES ☒ NO ☐

24. ACCIDENT, SUICIDE, HOMICIDE (Specify)

No.

25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

27. TIME (Month) (Day) (Year) (Hour)

28. INJURY OCCURRED

29. HOW DID INJURY OCCUR?

30. I hereby certify that I attended the deceased from 6/19/1950 to 6/22/1950 that I last saw the deceased alive on 6/22/1950, and that death occurred at 7:30 PM, from the causes and on the date stated above.

31. SIGNATURE

32. ADDRESS

33. DATE SIGNED

6/22/50.

34. BURIAL, CREMATION, REMOVAL (Specify)

Burial

35. DATE

6/24/50

36. NAME OF CEMETERY OR CREMATORY

New Cathedral

37. LOCATION (City, town, or county) (State)

Baltimore, Md.

38. DATE RECEIVED BY LOCAL REGISTRAR

39. REGISTRAR'S SIGNATURE

40. FUNERAL DIRECTOR

41. ADDRESS

42. JUN 23 1950

VS 150

43. 122a

50

5572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

5572

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HARRY A. HEANY

2. DATE OF DEATH

6/22/50.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland, B. COUNTY Baltimore.

5. FULL NAME OF HOSPITAL OR INSTITUTION

Chesapeake House & Hospital.

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 15-08A

7. D. STREET ADDRESS (If rural, give location)

2811 Allendale Rd.

8. DATE OF BIRTH

11/29/1872

9. AGE (In years last birthday)

77 yrs.

10. BIRTHPLACE (State or foreign country)

Maryland.

11. CITIZEN OF WHAT COUNTRY?

USA

12. MOTHER'S MAIDEN NAME

Catherine P. Debring

13. FATHER'S NAME

John P. Heany (HEANY)

14. SOCIAL SECURITY NO.

561.4

15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no or unknown)

(If yes, give war or dates of service)

16. INFORMANT ADDRESS

Charles M. Heany K. of C. Club

17. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary edema.

18. ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Epigastric Hernia & intestinal obstruction

19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Uremia

20. INTERVAL BETWEEN ONSET AND DEATH

3 days

21. DATE OF OPERATION

6/19/50

22. MAJOR FINDINGS OF OPERATION

Epigastric hernia.

23. AUTOPSY?

YES ☒ NO ☐

24. ACCIDENT, SUICIDE, HOMICIDE (Specify)

No.

25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

27. TIME (Month) (Day) (Year) (Hour)

28. INJURY OCCURRED

29. HOW DID INJURY OCCUR?

30. I hereby certify that I attended the deceased from 6/19/1950 to 6/22/1950 that I last saw the deceased alive on 6/22/1950, and that death occurred at 7:30 PM, from the causes and on the date stated above.

31. SIGNATURE

32. ADDRESS

33. DATE SIGNED

6/22/50.

34. BURIAL, CREMATION, REMOVAL (Specify)

Burial

35. DATE

6/24/50

36. NAME OF CEMETERY OR CREMATORY

New Cathedral

37. LOCATION (City, town, or county) (State)

Baltimore, Md.

38. DATE RECEIVED BY LOCAL REGISTRAR

39. REGISTRAR'S SIGNATURE

40. FUNERAL DIRECTOR

41. ADDRESS

42. JUN 23 1950

VS 150

43. 122a

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

WATER RESOURCES DIVISION  
RIVER AND WATERSHED MANAGEMENT  
SECTION

WATER RESOURCES  
DIVISION  
RIVER AND WATERSHED  
MANAGEMENT  
SECTION

WATER RESOURCES  
DIVISION  
RIVER AND WATERSHED  
MANAGEMENT  
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RIVER AND WATERSHED  
MANAGEMENT  
SECTION

WATER RESOURCES  
DIVISION  
RIVER AND WATERSHED  
MANAGEMENT  
SECTION

125  
50 5573BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5573  
Registered No.

|   |                           |  |                                       |
|---|---------------------------|--|---------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Gibson, Elizabeth Thelma</i>  |                           | 2. DATE OF DEATH <i>June 22, 1950</i>  |                                       |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                           | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i> |                                       |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION <i>Women's Hospital</i> |                           | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 23-02</i>                                 |                                       |
| C. Length of stay in Baltimore <i>38</i>  |                           | D. STREET ADDRESS (If rural, give location)<br><i>11 W. Randall St.</i>  |                                       |
| 5. SEX <i>F</i>   | 6. COLOR OR RACE <i>W</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>M</i>   | 8. DATE OF BIRTH <i>June 27, 1911</i> |
| 9. AGE (In years last birthday) <i>38</i>   |                           | 10. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>   |                                       |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Hair Wife</i>                         |                           | 10B. KIND OF BUSINESS OR INDUSTRY <i>-</i>   |                                       |
| 11. BIRTHPLACE (State or foreign country)<br><i>Baltimore, MD</i>   |                           | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>  |                                       |
| 13. FATHER'S NAME<br><i>Smith, Joseph E.</i>  |                           | 14. MOTHER'S MAIDEN NAME<br><i>Hoffman, Maude</i>  |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>   |                           | 16. SOCIAL SECURITY NO. <i>-</i>   |                                       |
| 17. INFORMANT <i>Patient.</i>   |                           | ADDRESS  |                                       |

|   |  |   |  |
|---|--|---|--|
| 18. <i>170 X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Carcinoma of breast</i><br>DUE TO       |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>10 mos.</i>  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><i>-</i><br>DUE TO  |  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><i>-</i><br>DUE TO   |  |   |  |
| 19A. DATE OF OPERATION <i>October, 1949</i>   |  | 19B. MAJOR FINDINGS OF OPERATION <i>Carcinoma breast left</i>   |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <i>-</i>   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <i>-</i>        |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>-</i>   |  |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) <i>-</i>  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  |
| 21F. HOW DID INJURY OCCUR? <i>-</i>   |  |   |  |
| 22. I hereby certify that I attended the deceased from <i>June 18, 1950</i> , to <i>June 22, 1950</i> , that I last saw the deceased alive on <i>June 22, 1950</i> , and that death occurred at <i>11:05 P.</i> m., from the causes and on the date stated above. |  |   |  |
| 23A. SIGNATURE <i>Eben P. Bennett</i><br>M. D.  |  | 23B. ADDRESS <i>Women's Hospital, Balt Md</i>   |  |
| 23C. DATE SIGNED <i>June 23, 1950</i>   |  |   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>   |  | 24B. DATE <i>6-26-1950</i>  |  |
| 24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i>   |  | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>                                       |  |
| DATE RECEIVED BY LOCAL REGISTRAR <i>JUN 23 1950</i>   |  | REGISTRAR'S SIGNATURE <i>Thurston Williams, M.D.</i>  |  |
| 25. FUNERAL DIRECTOR <i>G. Howard Strong</i>  |  | ADDRESS <i>3207 W. North Ave.</i>   |  |

CERTIFICATE OF DEATH

REGISTRATION OF DEATHS ACT, 1953

NO.

DATE OF DEATH

TIME

PLACE

CAUSE

AGE

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0 5574

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5574

Registered No. \_\_\_\_\_

|  |                                    |  |   |  |
|--|------------------------------------|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Joseph Jackson</i>   |                                    | 2. DATE OF DEATH <i>June 23, 1950</i>  |   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                    | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <i>Md.</i> B. COUNTY _____ |   |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>1625 N. Dallas St.</i>   |                                    | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore</i> <i>8-06</i>                 |   |  |
| C. Length of stay in Baltimore <i>Life</i> Yrs. Mos. Days  |                                    | D. STREET ADDRESS (If rural, give location)<br><i>1625 N. Dallas St.</i>   |   |  |
| 5. SEX<br><i>Male</i>  | 6. COLOR OR RACE<br><i>Colored</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Married</i>  | 8. DATE OF BIRTH<br><i>August 25, 1886</i> <i>63</i>            |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Laborer</i>  |                                    | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Social Security Employee</i>   | 11. BIRTHPLACE (State or foreign country)<br><i>Granite Md.</i> |  |
| 13. FATHER'S NAME<br><i>unknown</i>  |                                    | 14. MOTHER'S MAIDEN NAME<br><i>unknown</i>   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>unknown</i>   |                                    | 16. SOCIAL SECURITY NO.  | 17. INFORMANT ADDRESS<br><i>Mary Jackson, 1625 N. Dallas</i>    |  |
| 18. <i>592X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Crema a</i><br>DUE TO<br>ANTECEDENT CAUSES<br><i>Essential Hypertension</i><br>DUE TO<br><i>Chronic Nephritis</i><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><i>II</i> |                                    |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><i>?</i><br><i>?</i><br><i>?</i> |
| 19A. DATE OF OPERATION <i>0</i>  |                                    | 19B. MAJOR FINDINGS OF OPERATION   |   |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                    |  |   |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |                                    | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                                    |   |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                                    |  |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br><i>INJURY</i>   |                                    | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                    |   |  |
| 21F. HOW DID INJURY OCCUR?   |                                    |  |   |  |
| 22. I hereby certify that I attended the deceased from <i>5-2</i> , 1950, to <i>6-22</i> , 1950, that I last saw the deceased alive on <i>6-22</i> , 1950, and that death occurred at <i>5:30</i> p. m., from the causes and on the date stated above.   |                                    |  |   |  |
| 23A. SIGNATURE<br><i>Stanford P. Immendorf</i>   |                                    | 23B. ADDRESS<br><i>2309 Dund Rice Dr</i>   | 23C. DATE SIGNED<br><i>6-23-50</i>                              |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  |                                    | 24B. DATE<br><i>June 26/50</i>   | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Mt. Calvary Cem</i>    |  |
| 24D. LOCATION (City, town, or county) (State)<br><i>A. A. County Md.</i>   |                                    |  |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUN 23 1950</i>   |                                    | REGISTRAR'S SIGNATURE<br><i>Wilmington Williams, M.D.</i>  |   |  |
| 25. FUNERAL DIRECTOR<br><i>Mrs. Robert G. Elliot &amp; Daughter</i>  |                                    | ADDRESS<br><i>1129 N. Caroline St.</i>   |   |  |





235  
5575  
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5575  
Registered No.

|   |                              |   |  |  |   |
|---|------------------------------|---|--|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Edwena A. Houston</i>   |                              |   | 2. DATE OF DEATH<br><i>6-22-50</i>   |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>Mary</i>   |                              |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Md</i><br>B. COUNTY |  |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><i>Mary (Hospital)</i>          |                              |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 16-05</i>                   |  |   |
| C. Length of stay in Baltimore<br><i>20</i> Yrs. Mos. Days  |                              |   | D. STREET ADDRESS (If rural, give location)<br><i>2309 W. Lafayette Ave</i>  |  |   |
| 5. SEX<br><i>M</i>  | 6. COLOR OR RACE<br><i>W</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH<br><i>7/14/1890</i>   | 9. AGE (In years last birthday)<br><i>59</i> | 10. Under 1 Year Months: Days<br>11. Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Produce Inspector</i> |                              |   | 11. BIRTHPLACE (State or foreign country)<br><i>Chicago Ill</i>  |  |   |
| 12. CITIZEN OF WHAT COUNTRY?  |                              |   | 13. FATHER'S NAME<br><i>Thomas Houston</i>   |  |   |
| 14. MOTHER'S MAIDEN NAME<br><i>Sarah Henry</i>  |                              |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                 |  |   |
| 16. SOCIAL SECURITY NO.   |                              |   | 17. INFORMANT<br><i>PT.</i> ADDRESS  |  |   |

MEDICAL CERTIFICATION

|  |   |  |  |   |  |  |
|--|---|--|--|---|--|--|
| 18. <i>442 X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |   |  | CAUSE OF DEATH<br>(A) <i>Hypertensive Cardio Vascular Renal Disease</i><br>DUE TO<br>(B) <i>old healed Tbc.</i><br>DUE TO<br>(C) |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>2 years</i> |
| 19A. DATE OF OPERATION<br><i>0</i>   |   | 19B. MAJOR FINDINGS OF OPERATION   |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |   |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>INJURY  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |   |  |  |
| 22. I hereby certify that I attended the deceased from <i>6-17-50</i> , 19__, to <i>6-22-50</i> , 19__, that I last saw the deceased alive on <i>6-22</i> , 19__, and that death occurred at <i>6 P</i> m., from the causes and on the date stated above.  |   |  |  |   |  |  |
| 23A. SIGNATURE<br><i>H. Ruskin</i>   |   | 23B. ADDRESS<br><i>Mary</i>  |  | 23C. DATE SIGNED<br><i>6-22-50</i>                                  |  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  | 24B. DATE   | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Union City New Jersey</i>       | 24D. LOCATION (City, town, or county) (State)<br><i>Union City New Jersey</i>  |   |  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUN 23 1950</i>   |   | REGISTRAR'S SIGNATURE<br><i>Thurston Williams, M.D.</i>                  |  | 25. FUNERAL DIRECTOR<br><i>Wm. Cook &amp; Son - 1217 St Paul St</i> |  |  |



STATE OF NEW YORK  
CERTIFICATE OF DEATH

|                               |  |                            |  |                               |  |                                   |  |
|-------------------------------|--|----------------------------|--|-------------------------------|--|-----------------------------------|--|
| 1. Name of deceased           |  | 2. Sex                     |  | 3. Age                        |  | 4. Date of death                  |  |
| 5. Place of death             |  | 6. Cause of death          |  | 7. Manner of death            |  | 8. Signature of physician         |  |
| 9. Signature of registrar     |  | 10. Signature of informant |  | 11. Signature of witness      |  | 12. Signature of funeral director |  |
| 13. Signature of undertaker   |  | 14. Signature of cemetery  |  | 15. Signature of burial place |  | 16. Signature of interment        |  |
| 17. Signature of burial place |  | 18. Signature of interment |  | 19. Signature of burial place |  | 20. Signature of interment        |  |
| 21. Signature of burial place |  | 22. Signature of interment |  | 23. Signature of burial place |  | 24. Signature of interment        |  |
| 25. Signature of burial place |  | 26. Signature of interment |  | 27. Signature of burial place |  | 28. Signature of interment        |  |
| 29. Signature of burial place |  | 30. Signature of interment |  | 31. Signature of burial place |  | 32. Signature of interment        |  |
| 33. Signature of burial place |  | 34. Signature of interment |  | 35. Signature of burial place |  | 36. Signature of interment        |  |
| 37. Signature of burial place |  | 38. Signature of interment |  | 39. Signature of burial place |  | 40. Signature of interment        |  |
| 41. Signature of burial place |  | 42. Signature of interment |  | 43. Signature of burial place |  | 44. Signature of interment        |  |
| 45. Signature of burial place |  | 46. Signature of interment |  | 47. Signature of burial place |  | 48. Signature of interment        |  |
| 49. Signature of burial place |  | 50. Signature of interment |  | 51. Signature of burial place |  | 52. Signature of interment        |  |
| 53. Signature of burial place |  | 54. Signature of interment |  | 55. Signature of burial place |  | 56. Signature of interment        |  |
| 57. Signature of burial place |  | 58. Signature of interment |  | 59. Signature of burial place |  | 60. Signature of interment        |  |
| 61. Signature of burial place |  | 62. Signature of interment |  | 63. Signature of burial place |  | 64. Signature of interment        |  |
| 65. Signature of burial place |  | 66. Signature of interment |  | 67. Signature of burial place |  | 68. Signature of interment        |  |
| 69. Signature of burial place |  | 70. Signature of interment |  | 71. Signature of burial place |  | 72. Signature of interment        |  |
| 73. Signature of burial place |  | 74. Signature of interment |  | 75. Signature of burial place |  | 76. Signature of interment        |  |
| 77. Signature of burial place |  | 78. Signature of interment |  | 79. Signature of burial place |  | 80. Signature of interment        |  |
| 81. Signature of burial place |  | 82. Signature of interment |  | 83. Signature of burial place |  | 84. Signature of interment        |  |
| 85. Signature of burial place |  | 86. Signature of interment |  | 87. Signature of burial place |  | 88. Signature of interment        |  |
| 89. Signature of burial place |  | 90. Signature of interment |  | 91. Signature of burial place |  | 92. Signature of interment        |  |
| 93. Signature of burial place |  | 94. Signature of interment |  | 95. Signature of burial place |  | 96. Signature of interment        |  |
| 97. Signature of burial place |  | 98. Signature of interment |  | 99. Signature of burial place |  | 100. Signature of interment       |  |

|  |  |  |  |
|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Alberta, Cook</b>  |  | 2. DATE OF DEATH<br><b>June 22-1950</b>  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION) <b>Baltimore City Hospitals</b> location) <b>4940 Eastern Ave.</b> |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>  |  |
| D. STREET ADDRESS (If rural, give location) <b>1053 Argyle Ave. Z 1</b>  |  |  |  |
| 5. SEX <b>Female</b>   |  | 6. COLOR OR RACE <b>Negro</b>  |  |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Sep.</b>  |  | 8. DATE OF BIRTH <b>1885</b> 9. AGE (in years last birthday) <b>66</b> 10. If Under 1 Year Months <b>8</b> Days <b>19</b> If Under 24 Hours Hours <b></b> Min. <b></b> |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of worklog life, even if retired)  |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME <b>Henry, Thompson</b>   |  | 14. MOTHER'S MAIDEN NAME <b>Mary Jones</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT  |  | ADDRESS <b>Records B.C.H. 4940 Eastern Ave.</b>  |  |

|  |  |                                  |
|--|--|----------------------------------|
| 18. <b>260 X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cardiac Failure</b><br>DUE TO<br><b>Arteriosclerotic Cardio-vascular disease</b><br>DUE TO<br><b>Diabetes Mellitus</b> |  | INTERVAL BETWEEN ONSET AND DEATH |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |                                  |

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 19A. DATE OF OPERATION <b>6-19-50</b>   |  | 19B. MAJOR FINDINGS OF OPERATION <b>Diabetes Gangerne</b>  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>        |  |
| 21A. ACCIDENT WAS UNDER- LYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                |  |
| 21D. TIME (Month) (Day) (Year) (Hour) <b>4-20</b>   |  | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>6-22-</b> , 19 <b>50</b> , to <b>6-22-</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>6-22-</b> , 19 <b>50</b> , and that death occurred at <b>6:30 PM</b> from the causes and on the date stated above. |  |  |  |   |  |
| 23A. SIGNATURE <b>J. L. Rogers</b>  |  | 23B. ADDRESS <b>4940 Eastern Ave</b>   |  | 23C. DATE SIGNED <b>6-23-50</b>   |  |
| 24A. BURIAL, CREMA- TION, REMOVAL (Specify) <b>B</b>  |  | 24B. DATE <b>6-26-50</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY <b>Wm. Anderson</b>                                  |  |
| 24D. LOCATION (City, town, or county) <b>Balto. City</b>  |  | 24E. STATE (State)   |  |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR <b>JUN 23 1950</b>   |  | REGISTRAR'S SIGNATURE <b>William H. Williams</b>   |  | 25. FUNERAL DIRECTOR <b>Samuel W. Sullivan</b> ADDRESS <b>10 11 N. Arlington Ave 61</b> |  |

50-77

50-77

# CERTIFICATE CORRECTED

8-10-50

50 5577

BALTIMORE CITY HEALTH DEPARTMENT

50 5577

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*Casimer. F. Brocki*

2. DATE  
OF  
DEATH

*June 21, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland *Baltimore City*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE *Maryland* B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

*229. N. MILTON ave*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
*Baltimore City 6-02*

D. STREET ADDRESS (If rural, give location)  
*229. N. MILTON ave*

C. Length of stay in Baltimore

*59 65 yrs.*

Yrs.  
Mos.  
Days

5. SEX

*male*

6. COLOR OR RACE

*white*

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

*married*

8. DATE OF BIRTH

*Feb. 23, 1885*

9. AGE (in years last birthday)

*65*

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*LABORER*

10B. KIND OF BUSINESS OR INDUSTRY

*Packing House*

11. BIRTHPLACE (State or foreign country)

*POLAND*

12. CITIZEN OF WHAT COUNTRY?

*U.S.A*

13. FATHER'S NAME

*WILLIAM BROCKI*

14. MOTHER'S MAIDEN NAME

*FRANCIS PAPUCKA*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

*217-07-8525*

17. INFORMANT

*Elizabeth Brocki 229. N. Milton*

ADDRESS

18. *442 X*

*217-07-8525*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

*Hypertensive Cardio renal dis*

DUE TO

ANTECEDENT CAUSES

(B)

*Bright's Disease*

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *Feb 20*, 19*50*, to *June 21*, 19*50*, that I last saw the deceased alive on *June 20*, 19*50*, and that death occurred at *12:05* m., from the causes and on the date stated above.

23A. SIGNATURE

*Charles E. Mac Meine*

M. D.

23B. ADDRESS

*2900 E. Belts St*

23C. DATE SIGNED

*June 22, 1950*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

*June 24, 1950*

24C. NAME OF CEMETERY OR CREMATORY

*HOLY REDEEMER*

24D. LOCATION (City, town or county) (State)

*Belair Road*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Huntington Williams, M.D.*

25. FUNERAL DIRECTOR

*MERDEL'S DIPPAL*

ADDRESS

*312-5 Highland ave*

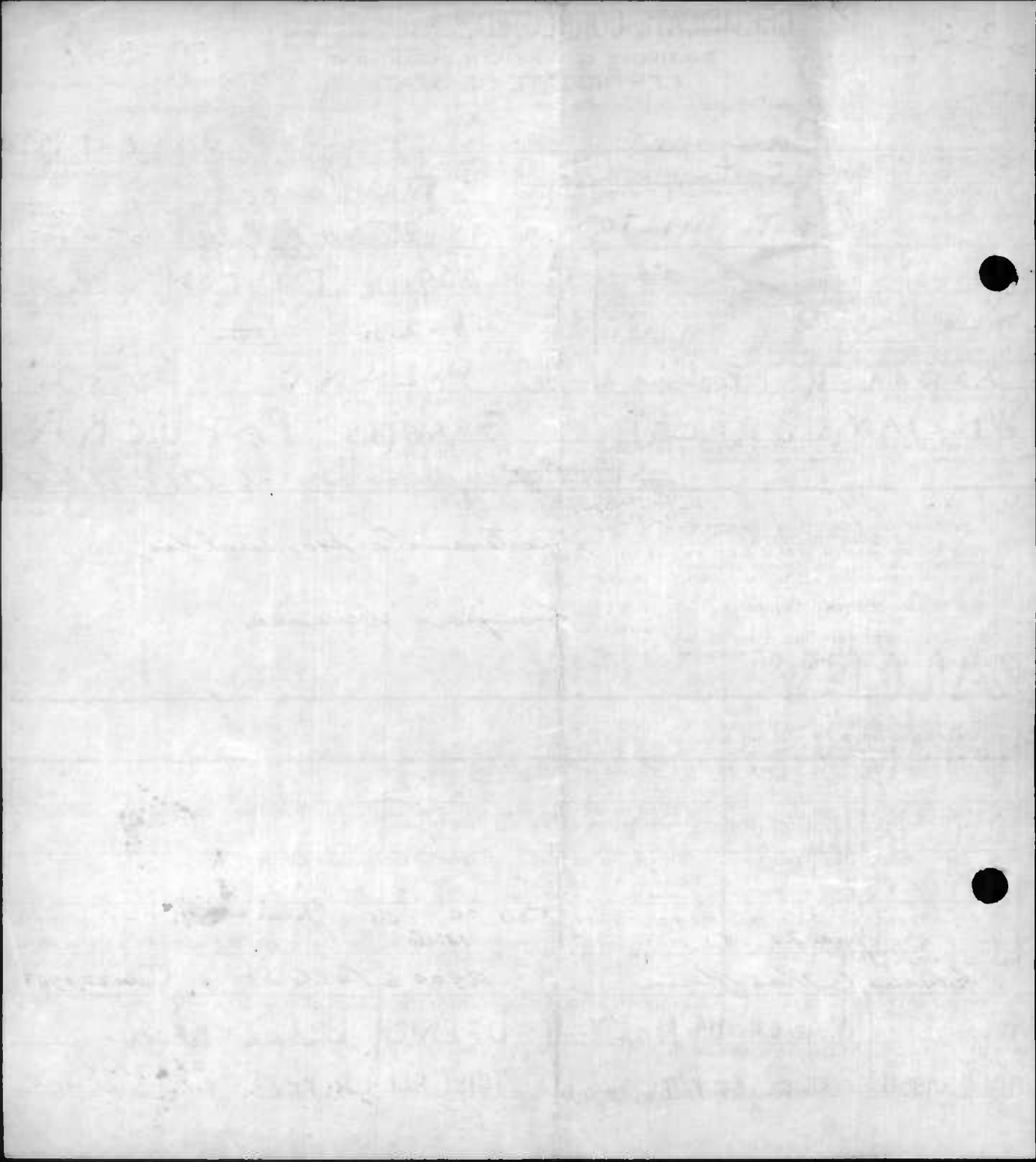
*JUN 23 1950*

VS 150

*98860*

*131a*

MEDICAL CERTIFICATION



| 620 50 5578  |  |  |  | 7-550  |  |  |  | 50 5578  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT   |  |  |  |  |  |  |  | Registered No.   |  |  |  |
| BIRTH NO.  |  |  |  |  |  |  |  |  |  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print)   |  |  |  | 2. DATE OF DEATH   |  |  |  |  |  |  |  |
| WALTER THOMAS MARK   |  |  |  | June 21, 1950  |  |  |  |  |  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |  |  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE B. COUNTY  |  |  |  |  |  |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION  |  |  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)   |  |  |  |  |  |  |  |
| Baltimore City Hospital  |  |  |  | Essex Island 5300  |  |  |  |  |  |  |  |
| 5. SEX M   |  |  |  | 6. COLOR OR RACE W   |  |  |  |  |  |  |  |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  |  |  |  | 8. DATE OF BIRTH   |  |  |  |  |  |  |  |
| Married  |  |  |  | June 14, 1921  |  |  |  |  |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |  |  | 9. AGE (In years last birthday)  |  |  |  |  |  |  |  |
|  |  |  |  | 28   |  |  |  |  |  |  |  |
| 10B. KIND OF BUSINESS OR INDUSTRY  |  |  |  | 11. BIRTHPLACE (State or foreign country)  |  |  |  |  |  |  |  |
|  |  |  |  | Springfield, Mass.   |  |  |  |  |  |  |  |
| 13. FATHER'S NAME  |  |  |  | 12. CITIZEN OF WHAT COUNTRY?   |  |  |  |  |  |  |  |
| Walter T. Mark, Jr.  |  |  |  | USA  |  |  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |  |  |  | 17. INFORMANT  |  |  |  |  |  |  |  |
|  |  |  |  | Wm. June Mark, Jr.   |  |  |  |  |  |  |  |
| 16. SOCIAL SECURITY NO.  |  |  |  | ADDRESS  |  |  |  |  |  |  |  |
| 316-28-7772  |  |  |  | 100, Saint Paul  |  |  |  |  |  |  |  |
| 18. E902.3 CAUSE OF DEATH  |  |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  |  |  |  |  |  |  |  | (A) Fracture of skull with contusion of brain                                  |  |  |  |
| ANTECEDENT CAUSES  |  |  |  |  |  |  |  | (B)  |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  |  |  |  |  |  |  | (C)  |  |  |  |
| II Acute Alcoholism  |  |  |  |  |  |  |  |  |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |  |  |  |  |  |  |  |  |  |  |
| 19A. DATE OF OPERATION   |  |  |  | 19B. MAJOR FINDINGS OF OPERATION   |  |  |  | 20. AUTOPSY?   |  |  |  |
|  |  |  |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  |  |  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)       |  |  |  |
|  |  |  |  | disposal plant   |  |  |  | Back River, Essex, Maryland  |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  |  |  | 21E. INJURY OCCURRED   |  |  |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| June 21 1950 A m.  |  |  |  | WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | Fell off table into pit  |  |  |  |
| 22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |  |  |  |  |  |  |  |  |  |  |  |
| 23A. SIGNATURE   |  |  |  | 23B. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/> |  |  |  | 23C. DATE SIGNED   |  |  |  |
| RS Fisher  |  |  |  | M.D.   |  |  |  | June 21, 1950  |  |  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  |  |  |  | 24B. DATE  |  |  |  | 24C. NAME OF CEMETERY OR CREMATORY   |  |  |  |
| Burial   |  |  |  | June 24 1950   |  |  |  | Mount Carmel Cem. Roland St.   |  |  |  |
| 24D. LOCATION (City, town, or county) (State)  |  |  |  | 25. FUNERAL DIRECTOR   |  |  |  | ADDRESS  |  |  |  |
| JUN 23 1950  |  |  |  | Risington Williams, M.D.   |  |  |  | Ed DIPPEN 31 Nightingale   |  |  |  |
| VS 151   |  |  |  | N-803.2  |  |  |  | 98499  |  |  |  |
|  |  |  |  |  |  |  |  | 186a   |  |  |  |





| BALTIMORE CITY HEALTH DEPARTMENT   |                           |  |   | 50 5579  |  |
|--|---------------------------|--|---|--|--|
| CERTIFICATE OF DEATH   |                           |  |   | Registered No.   |  |
| 1. NAME OF DECEASED<br>(Type or Print) CHARLES HENRY SCHMIER   |                           |  |   | 2. DATE OF DEATH<br>June 23, 1950  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                           |  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>Mercy Hospital   |                           |  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore                  |  |
| C. Length of stay in Baltimore<br>Yrs. Mos. Days   |                           |  |   | D. STREET ADDRESS (If rural, give location)<br>2516 Aisquith Street  |  |
| 5. SEX<br>Male   | 6. COLOR OR RACE<br>White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Married | 8. DATE OF BIRTH<br>2/7/1884  | 9. AGE (In years last birthday)<br>66  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Watchman |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Watchman  |                           |  | 10B. KIND OF BUSINESS OR INDUSTRY<br>Marine                             |  | 11. BIRTHPLACE (State or foreign country)<br>Balto. Md.  |
| 12. CITIZEN OF WHAT COUNTRY?   |                           |  | 13. FATHER'S NAME<br>(Unknown) Schmier                                  |  |  |
| 14. MOTHER'S MAIDEN NAME<br>Caroline (Unknown)   |                           |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br>No |  |  |
| 16. SOCIAL SECURITY NO.<br>215-10-2598   |                           |  | 17. INFORMANT ADDRESS<br>Catherine Schmier 2516 Aisquith St             |  |  |
| 18. E 901.3<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br>(A) Fracture of skull, vertebrae, pelvis, and ribs<br>DUE TO<br>(B) Hemorrhage into right chest<br>DUE TO<br>(C)<br>INTERVAL BETWEEN ONSET AND DEATH   |                           |  |   |  | 19. DATE OF OPERATION  |
| 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                           |  |   |  | 21. TIME (Month) (Day) (Year) (Hour)<br>June 22, 1950 10:15 Pm   |
| 22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |                           |  |   |  | 23. DATE SIGNED<br>6-23-50   |
| 24. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                           |  |   |  | 25. FUNERAL DIRECTOR ADDRESS<br>Cook Inc. 1217 St. Paul St   |
| 26. REGISTRAR'S SIGNATURE<br>Wilmington Williams, M.D.   |                           |  |   |  | 27. V. S. 151  |



412  
5580BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5580

Registered No.

|   |                               |   |                                   |
|---|-------------------------------|---|-----------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Margaret Filipkowski</b>  |                               | 2. DATE OF DEATH <b>6.22.50</b>   |                                   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>Doctors Hospital</b>   |                               | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY |                                   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Doctor's Hospital</b>  |                               | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 2-03</b>                          |                                   |
| c. Length of stay in Baltimore <b>40 years</b>  |                               | D. STREET ADDRESS (If rural, give location) <b>1615 Shakespeare Str. E</b>  |                                   |
| 5. SEX <b>female</b>  | 6. COLOR OR RACE <b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>  | 8. DATE OF BIRTH <b>4/12/1883</b> |
| 9. AGE (in years, last birthday) <b>67</b>  |                               | 10. BIRTHPLACE (State or foreign country) <b>Poland</b>   |                                   |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                               | 12. CITIZEN OF WHAT COUNTRY?  |                                   |
| 13. FATHER'S NAME <b>cehuacen</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>cehuacen</b>  |                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)   |                               | 16. SOCIAL SECURITY NO.   |                                   |
| 17. INFORMANT <b>Joseph Filipkowski</b>   |                               | ADDRESS <b>above</b>  |                                   |
| 18. <b>585X</b> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Empyema gall bladder, <sup>unnoted</sup> hepatitis <sup>about 2 weeks</sup> pancreatitis</b><br>DUE TO<br><b>A. Uremia</b><br>DUE TO<br><b>B. Arterio-sclerotic Cardio-vascular renal disease</b><br>INTERVAL BETWEEN ONSET AND DEATH |                               |   |                                   |
| 19. MAJOR FINDINGS OF OPERATION <b>Empyema gall bladder, hepatitis, pancreatitis</b>  |                               |   |                                   |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |   |                                   |
| 21A. DATE OF OPERATION <b>6/17/50</b>   |                               | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                                   |                                   |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                               | 21D. TIME (Month) (Day) (Year) (Hour)   |                                   |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                               | 21F. HOW DID INJURY OCCUR?  |                                   |
| 22. I hereby certify that I attended the deceased from <b>6/17/50</b> , 19 <b>50</b> , to <b>6/22</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>6/22</b> , 19 <b>50</b> , and that death occurred at <b>5:55</b> p. m., from the causes and on the date stated above.   |                               |   |                                   |
| 23A. SIGNATURE <b>Modesto Graziano</b>  |                               | 23B. ADDRESS <b>2802 Hayford Rd</b>   |                                   |
| 23C. DATE SIGNED <b>6/22/50</b>   |                               |   |                                   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 24B. DATE <b>27 June 50</b>   |                                   |
| 24C. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary</b>   |                               | 24D. LOCATION (City, town, or county) (State) <b>Sermon Hill Rd.</b>  |                                   |
| DATE RECEIVED BY LOCAL REGISTRAR <b>JUN 24 1950</b>   |                               | REGISTRAR'S SIGNATURE <b>Wm. J. Galikowski</b>  |                                   |
| 25. FUNERAL DIRECTOR <b>Wm. J. Galikowski</b>   |                               | ADDRESS <b>2007 Eastern Ave 127a</b>  |                                   |

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

Given 20 June 1941, 1941  
Wm. C. Sullivan  
J. C. Sullivan

362  
5581BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5581

|   |                              |   |                                   |
|---|------------------------------|---|-----------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <i>John T. Leterski</i>  |                              | 2. DATE OF DEATH<br><i>June 21 - 1950</i>   |                                   |
| 3. PLACE OF DEATH:<br>a. Baltimore City, Maryland <i>Balto. City</i>  |                              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <i>Maryland</i> b. COUNTY <i>Balto.</i> |                                   |
| b. FULL NAME OF (If not in hospital or institution, give street address or location)<br><i>507 S. Lakewood Ave</i>  |                              | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 1-03</i>                                     |                                   |
| c. Length of stay in Baltimore <i>Life</i>  |                              | d. STREET ADDRESS (If rural, give location)<br><i>507 S. Lakewood Ave</i>   |                                   |
| 5. SEX<br><i>M</i>  | 6. COLOR OR RACE<br><i>W</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Married</i>   | 8. DATE OF BIRTH<br><i>Dec 21</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Trucking</i>  |                              | 9. AGE (In years, last birthday)<br><i>52</i>   |                                   |
| 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Transfer Business</i>   |                              | 11. BIRTHPLACE (State or foreign country)<br><i>Balto.</i>  |                                   |
| 13. FATHER'S NAME<br><i>Anthony Brozkowski</i>  |                              | 12. CITIZEN OF WHAT COUNTRY?<br><i>Poland</i>   |                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><i>No</i>  |                              | 16. SOCIAL SECURITY NO.<br><i>218-12-2653</i>   |                                   |
| 17. INFORMANT<br><i>Johanna Leterski</i>  |                              | ADDRESS<br><i>507 S. Lakewood Ave</i>   |                                   |
| 18. <i>420.1</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Coronary occlusion</i>            |                              | INTERVAL BETWEEN ONSET AND DEATH<br><i>about 5 minutes</i>  |                                   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                              |   |                                   |
| 19A. DATE OF OPERATION<br><i>0</i>  |                              | 19B. MAJOR FINDINGS OF OPERATION  |                                   |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                              |   |                                   |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                              | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |                                   |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                              |   |                                   |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |                              | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                 |                                   |
| 21F. HOW DID INJURY OCCUR?  |                              |   |                                   |
| 22. I hereby certify that I attended the deceased from <i>June 21</i> , 19 <i>50</i> , to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <i>11:50 P</i> m., from the causes and on the date stated above.   |                              |   |                                   |
| 23A. SIGNATURE<br><i>Charles J. Graziano</i>  |                              | 23B. ADDRESS<br><i>2802 Hayford Rd</i>  |                                   |
| 23C. DATE SIGNED<br><i>6/23/50</i>  |                              |   |                                   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |                              | 24B. DATE<br><i>26 June 50</i>  |                                   |
| 24C. NAME OF CEMETERY OR CREMATORY<br><i>St. Stanislaus</i>   |                              | 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore Ave.</i>  |                                   |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUN 24 1950</i>  |                              | REGISTRAR'S SIGNATURE<br><i>Huntington Williams</i>   |                                   |
| 25. FUNERAL DIRECTOR<br><i>W. S. Tralowski</i>  |                              | ADDRESS<br><i>2007 Eastern Ave</i>  |                                   |

Mr. Luzzano

2802 Hartford Rd.



320  
0 5582BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

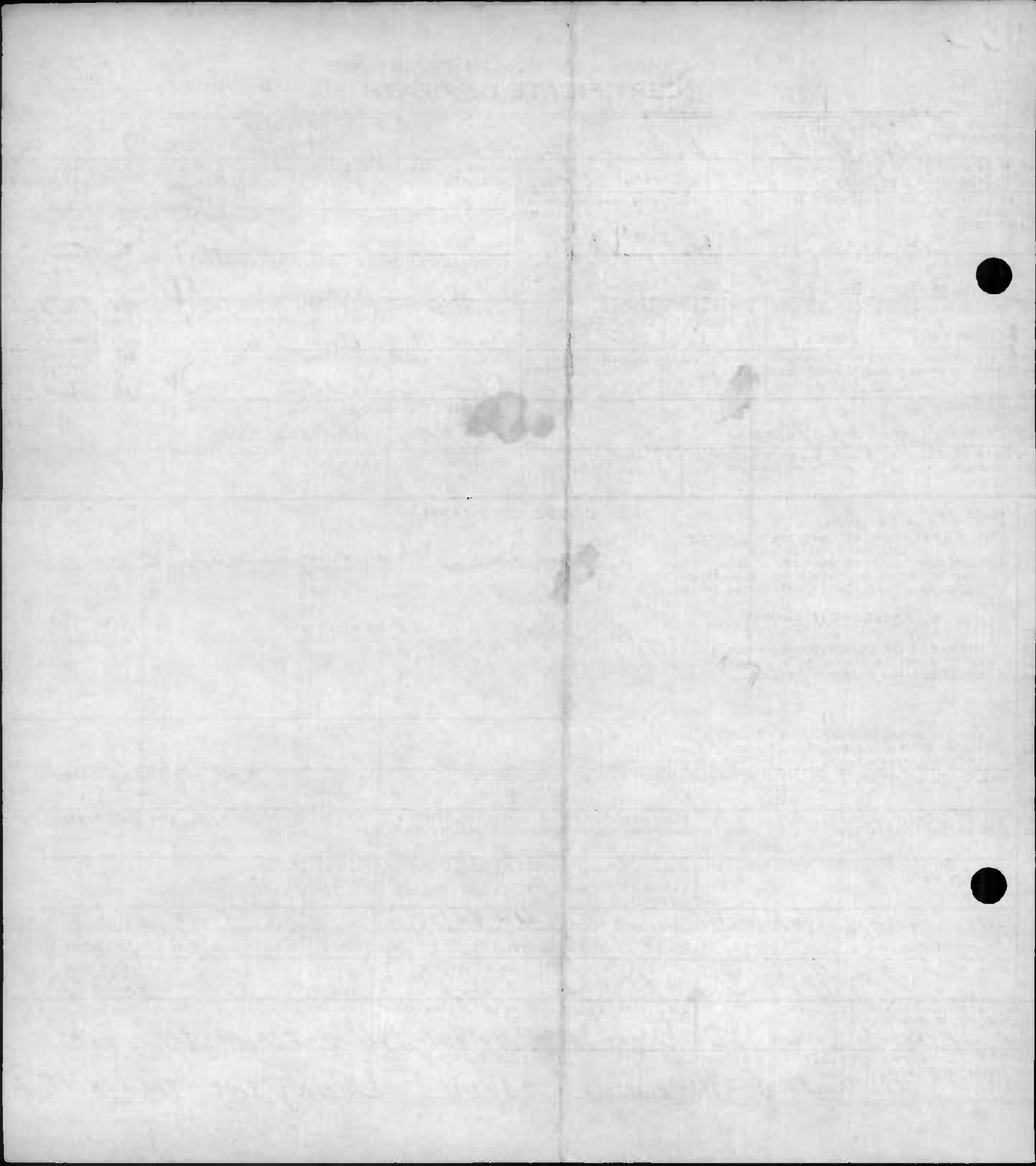
Registered No. 50 5582

|  |                               |  |   |
|--|-------------------------------|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Anna Kotecki</b>   |                               | 2. DATE OF DEATH <b>June 22, 1950</b>  |   |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland 109 S. Washington St.</b>   |                               | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>2-01</b> |   |
| 5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br><b>00</b>   |                               | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>   |   |
| 6. LENGTH OF STAY IN BALTIMORE <b>65</b> Yrs. <del>Mo.</del> <del>Wks.</del>   |                               | D. STREET ADDRESS (If rural, give location)<br><b>109 S. Washington St.</b>  |   |
| 7. SEX <b>Female</b>   | 8. COLOR OR RACE <b>White</b> | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>   | 10. DATE OF BIRTH <b>September 1880</b> |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housework</b>   |                               | 12. AGE (In years last birthday) <b>69</b>   |   |
| 13. FATHER'S NAME <b>Ushlar</b>  |                               | 14. CITIZEN OF WHAT COUNTRY? <b>Germany</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)  |                               | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT <b>Edward Kotecki</b>  |                               | ADDRESS <b>109 S. Washington St.</b>   |   |
| 18. <b>420.1</b> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Caravan of thrombosis - Ch. myelitis</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>340.</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                               |  |   |
| 19A. DATE OF OPERATION <b>0</b>  |                               | 19B. MAJOR FINDINGS OF OPERATION   |   |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               |  |   |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |                               | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  |   |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                               |  |   |
| 22. TIME (Month) (Day) (Year) (Hour)   |                               | 23. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                      |   |
| 24. HOW DID INJURY OCCUR?  |                               |  |   |
| 25. I hereby certify that I attended the deceased from <b>5/10/50</b> , to <b>6/22/50</b> , that I last saw the deceased alive on <b>6/21/50</b> , and that death occurred at <b>6 a. m.</b> , from the causes and on the date stated above.   |                               |  |   |
| 26. SIGNATURE <b>H. J. Thompson</b>  |                               | 27. ADDRESS <b>1616 E. East Ave</b>  |   |
| 28. DATE SIGNED <b>6/23/50</b>   |                               |  |   |
| 29A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 29B. DATE <b>6/26/50</b>   |   |
| 29C. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cemetery</b>   |                               | 29D. LOCATION (City, town, or county) (State) <b>German Hill Road</b>  |   |
| 30. DATE RECEIVED BY LOCAL REGISTRAR <b>JUN 24 1950</b>  |                               | 31. REGISTRAR'S SIGNATURE <b>Wm. J. Williams, M.D.</b>   |   |
| 32. FUNERAL DIRECTOR <b>Mary Weber</b>   |                               | 33. ADDRESS <b>401 S. Chester Street</b>   |   |



公司

| 155  |                                  | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH  |   | 50 5583<br>Registered No.   |   |
|--|----------------------------------|---|---|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Mary Elizabeth Hoffman</i>   |                                  |   | 2. DATE OF DEATH <i>21 June 50</i>  |   |   |
| 3. PLACE OF DEATH<br>A. Baltimore City <i>Maryland St. Joseph's Hsp.</i>   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>md.</i> B. COUNTY <i>Balt.</i> |   |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION <i>St. Joseph's Hospital</i>   |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore</i>                                    |   |   |
| C. Length of stay in Baltimore <i>20 yrs.</i>  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><i>418 Grindall St.</i>  |   |   |
| 5. SEX<br><i>Female</i>  | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Widow</i>   | 8. DATE OF BIRTH<br><i>Nov. 17, 1873</i>  | 9. AGE (In years last birthday)<br><i>76</i>  | 10. Under 1 Year<br>Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                                  |   | 11. BIRTHPLACE (State or foreign country)<br><i>Westminster Md</i>  |   |   |
| 10B. KIND OF BUSINESS OR INDUSTRY  |                                  |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |   |   |
| 13. FATHER'S NAME<br><i>John Holmes</i>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><i>MARY STEINSON</i>  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |                                  |   | 16. SOCIAL SECURITY NO.   |   |   |
| 17. INFORMANT  |                                  |   | ADDRESS   |   |   |
| 18. <i>450.0</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Cardiac decompensation bho.</i>    |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><i>1 yr</i>   |   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><i>Arterio Sclerosis</i>   |                                  |   |   |   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                                  |   |   |   |   |
| 19A. DATE OF OPERATION <i>0</i>  |                                  | 19B. MAJOR FINDINGS OF OPERATION  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |   |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>INJURY  |                                  | 21E. INJURY OCCURRED<br>WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I hereby certify that I attended the deceased from <i>Sept 19, 1950</i> , to <i>June 21, 1954</i> that I last saw the deceased alive on <i>June 21, 1950</i> , and that death occurred at <i>8 P. m.</i> , from the causes and on the date stated above. |                                  |   |   |   |   |
| 23A. SIGNATURE<br><i>John F. Denny</i>   |                                  | 23B. ADDRESS<br><i>1279 William St.</i>   |   | 23C. DATE SIGNED<br><i>10/22/50</i>   |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>BURIAL</i>   |                                  | 24B. DATE<br><i>6-24-50</i>   |   | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Deer Park (Methodist)</i>                  |   |
| 24D. LOCATION (City, town, or county) (State)<br><i>Westminster, Md.</i>   |                                  |   |   |   |   |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUN 24 1950</i>   |                                  | REGISTRAR'S SIGNATURE<br><i>Huntington Williams</i>   |   | 25. FUNERAL DIRECTOR<br><i>John F. Denny Inc</i>                                    |   |
|  |                                  |   |   | ADDRESS<br><i>715 Light St.</i>   |   |



222

5584

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

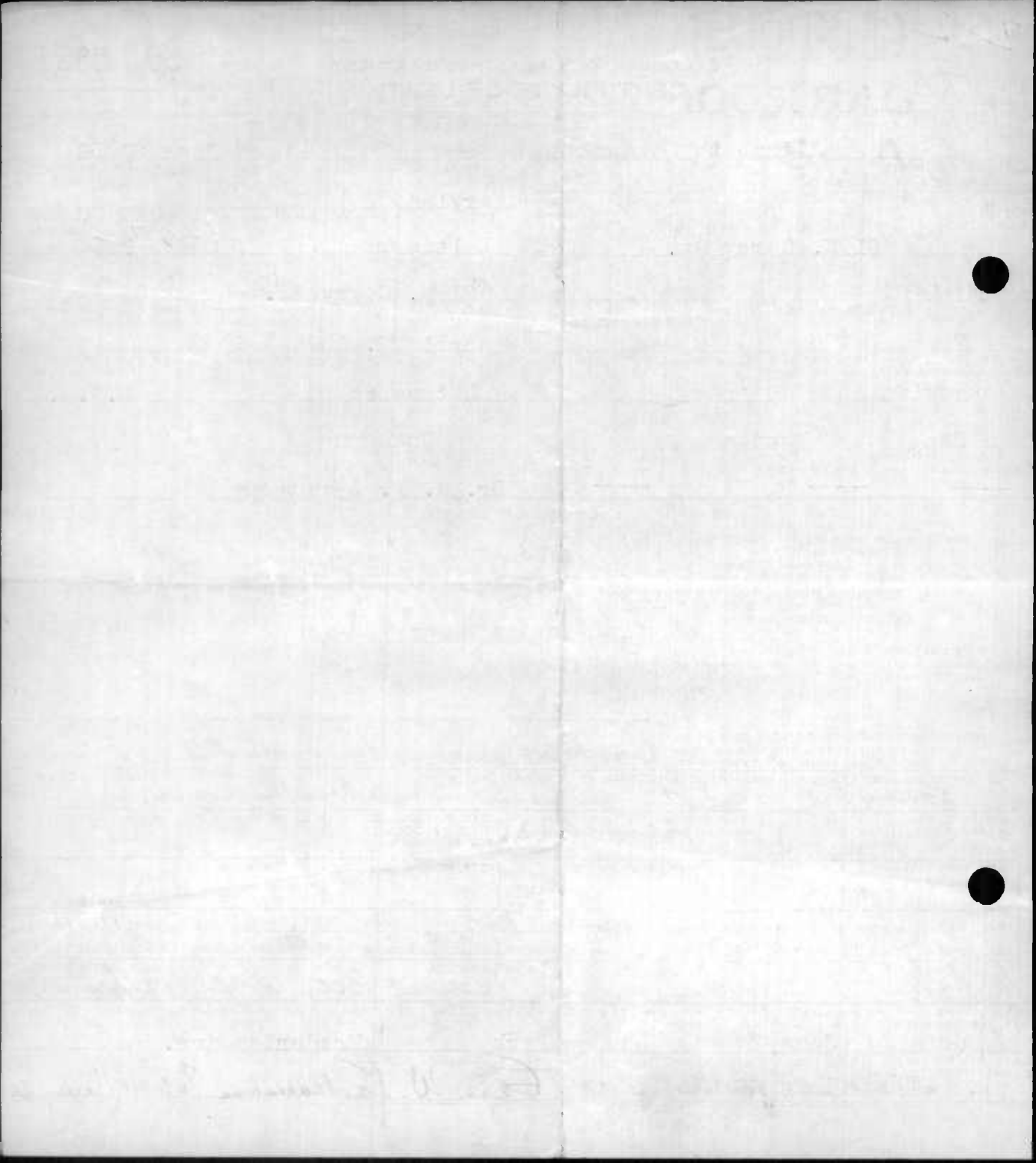
50 5584

Registered No. \_\_\_\_\_

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Elizabeth Lazauskas</b>  |  |  | 2. DATE OF DEATH <b>June 20 50</b>   |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |  |  | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>C. CITY OR TOWN <b>Baltimore</b> (If outside corporate limits, write RURAL, and give township) <b>18-02</b><br>D. STREET ADDRESS (If rural, give location) <b>21 N. Carey St.</b> |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION  |  |  | 5. SEX <b>F</b> 6. COLOR OR RACE <b>W</b> 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>   |  |  |
| C. Length of stay in Baltimore   |  |  | 8. DATE OF BIRTH <b>April 22, 1890 60</b> 9. AGE (In years last birthday) <b>60</b> 11. BIRTHPLACE (State or foreign country) <b>Lithuania</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> |  |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13. FATHER'S NAME <b>Benedict Maldutis</b>   |  |  | 14. MOTHER'S MAIDEN NAME <b>Unknown</b>  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)                          |  |  | 16. SOCIAL SECURITY NO.  |  |  |
| 17. INFORMANT <b>Dr. A. P. Lazauskas</b>   |  |  | ADDRESS  |  |  |

|  |  |  |   |  |  |   |  |  |
|--|--|--|---|--|--|---|--|--|
| 18. <b>171X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  |  |  | CAUSE OF DEATH<br>(A) <b>Metastatic Carcinoma</b><br>DUE TO   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 years.</b>                                 |  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  |  | (B) <b>Carcinoma Cervix</b><br>DUE TO   |  |  | <b>7 years</b>  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |  | (C) <b>Pneumonia, anemia, malnutrition</b>  |  |  | <b>6 months</b>   |  |  |
| 19A. DATE OF OPERATION <b>5-16-49</b>  |  |  | 19B. MAJOR FINDINGS OF OPERATION<br><b>Metastatic carcinoma, retroperitoneal lymph nodes</b>              |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  |  | 21F. HOW DID INJURY OCCUR?  |  |  |
| 22. I hereby certify that I attended the deceased from <b>Nov. 1949</b> , to <b>20 June, 1950</b> that I last saw the deceased alive on <b>19 June, 1950</b> , and that death occurred at <b>3:30 p.m.</b> , from the causes and on the date stated above. |  |  |   |  |  |   |  |  |
| 23A. SIGNATURE<br><b>Robert E. Sheppard</b>  |  |  | 23B. ADDRESS<br><b>Medical Arts Bldg.</b>   |  |  | 23C. DATE SIGNED<br><b>22 June, 1950</b>  |  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  | 24B. DATE<br><b>June 24</b>   |  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Louisa Park</b>                            |  |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Frederich Ave.</b>   |  |  | 24E. FUNERAL DIRECTOR<br><b>Chas. W. Kachauskas</b>   |  |  | 24F. ADDRESS<br><b>703 McHenry St.</b>  |  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 24 1950</b>   |  |  | REGISTRAR'S SIGNATURE<br><b>Wm. W. Williams, Jr.</b>  |  |  | VS 150  |  |  |

48a



520  
5585BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5585  
Registered No.

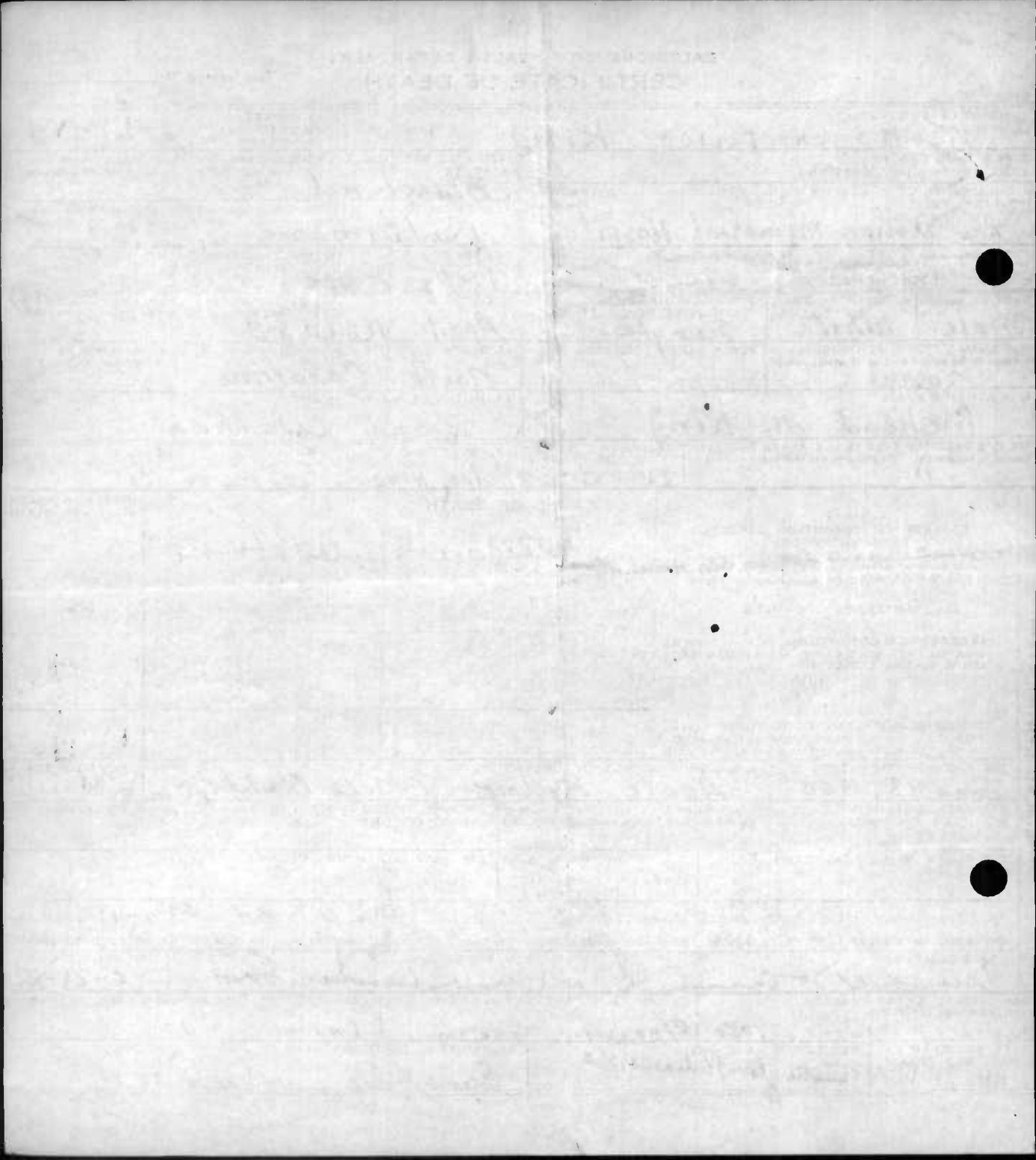
BIRTH NO.

|  |                                  |  |   |  |  |
|--|----------------------------------|--|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Roger Prior King</b>   |                                  |  | 2. DATE OF DEATH<br><b>6-22-50</b>  |  |  |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>   |                                  |  | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>The Union Memorial Hospital</b>  |                                  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 13-07</b>                      |  |  |
| C. Length of stay in Baltimore <b>48 years</b>   |                                  |  | D. STREET ADDRESS (If rural, give location)<br><b>Kelly Place (1112)</b>  |  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Single</b> | 8. DATE OF BIRTH<br><b>April 1887</b>   |  | 9. AGE (In years last birthday)<br><b>63</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None WEAVER TEXTILES</b> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY                                |   | 11. BIRTHPLACE (State or foreign country)<br><b>North Carolina</b> |  |
| 13. FATHER'S NAME<br><b>Richard M. King</b>  |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>Zona Walker</b>  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>No</b>                           |                                  |  | 16. SOCIAL SECURITY NO.<br><b>213-03-7558</b>   |  |  |
|  |                                  |  | 17. INFORMANT ADDRESS<br><b>Rufus King 703 Berry ST</b>   |  |  |

|   |   |                                  |
|---|---|----------------------------------|
| 18. <b>586X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Alcoholism, Bile</b> | CAUSE OF DEATH<br>(A) <b>Alcoholism, Bile</b><br>DUE TO<br>(B)<br>DUE TO<br>(C) | INTERVAL BETWEEN ONSET AND DEATH |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |   |                                  |

MEDICAL CERTIFICATION

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 19A. DATE OF OPERATION<br><b>June 18, 1950</b>  |  | 19B. MAJOR FINDINGS OF OPERATION<br><b>Acute Hydrops of Gall Bladder</b>                                  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>6-18</b> , 19 <b>50</b> , to <b>6-22</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>6-22</b> , 19 <b>50</b> , and that death occurred at <b>10:50 p.m.</b> , from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE<br><b>Marshall D. Carnahan</b>   |  | 23B. ADDRESS<br><b>Marshall D. Carnahan</b>   |  | 23C. DATE SIGNED<br><b>6-23-50</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 24B. DATE<br><b>June 26, 1950</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Greenwood Cemetery</b>                     |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Laurel Md.</b>  |  | 24E. NAME OF CEMETERY OR CREMATORY  |  | 24F. LOCATION (City, town, or county) (State)                                       |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 24 1950</b>  |  | REGISTRAR'S SIGNATURE<br><b>Wilmington Williams, MD</b>   |  | 25. FUNERAL DIRECTOR ADDRESS<br><b>Glenn F. Self 814 West 36 St.</b>                |  |





452  
5586

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5586

|   |                           |  |  |
|---|---------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>JAMES BERNARD WILLINGHAM</b>  |                           | 2. DATE OF DEATH <b>June 23, 1950</b>  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                           | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>US Marine Hospital</b><br><b>Wyman Pk. Drive &amp; 31st St.</b>  |                           | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>8-05</b>           |  |
| C. Length of stay in Baltimore <b>Lifetime</b> Yrs. Mos. Days   |                           | D. STREET ADDRESS (If rural, give location)<br><b>2001 Cliftwood Ave.</b>  |  |
| 5. SEX <b>M</b>   | 6. COLOR OR RACE <b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>  | 8. DATE OF BIRTH <b>9/28/91</b>  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>   |                           | 10B. KIND OF BUSINESS OR INDUSTRY <b>DARRY PROD</b>  | 9. AGE (In years last birthday) <b>58</b>  |
| 11. BIRTHPLACE (State or foreign country) <b>Md.</b>  |                           | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |
| 13. FATHER'S NAME <b>Harry G. Willingham</b>  |                           | 14. MOTHER'S MAIDEN NAME <b>Carrie Schly</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes WW I</b>   |                           | 16. SOCIAL SECURITY NO. <b>218-05-1628</b>   |  |
| 17. INFORMANT ADDRESS <b>Records- US Marine Hospital, Balto, Md.</b>  |                           |  |  |
| 18. <b>442X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Hypertensive cardiovascular disease</b><br>DUE TO<br>ANTECEDENT CAUSES<br><b>Cardiomegaly</b><br>DUE TO<br><b>Nephrosclerosis</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                           |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Unknown</b><br><b>Unknown</b><br><b>Unknown</b> |
| 19A. DATE OF OPERATION <b>0</b>   |                           | 19B. MAJOR FINDINGS OF OPERATION   |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                           |  |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                           | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                              |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                           |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) <b>June 23, 1950, 10:10A</b>  |                           | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                 |  |
| 21F. HOW DID INJURY OCCUR?  |                           |  |  |
| 22. I hereby certify that I attended the deceased from <b>June 12, 1950</b> , to <b>June 23, 1950</b> , that I last saw the deceased alive on <b>June 23, 1950</b> and that death occurred at <b>10:10A</b> m., from the causes and on the date stated above.   |                           |  |  |
| 23A. SIGNATURE <b>John L. Wilson</b>  |                           | 23B. ADDRESS <b>US Marine Hospital, Balto, Md.</b>   |  |
| 23C. DATE SIGNED <b>6/23/50</b>   |                           |  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |                           | 24B. DATE <b>6-26-1950</b>   |  |
| 24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>  |                           | 24D. LOCATION (City, town, or county) (State) <b>Greenfield Rd. Annapolis</b>  |  |
| DATE RECEIVED BY LOCAL REGISTRAR <b>JUN 24 1950</b>   |                           | REGISTRAR'S SIGNATURE <b>Wilmington Williams, Md</b>   |  |
| 25. FUNERAL DIRECTOR <b>J. Walter Conklin</b>   |                           | ADDRESS <b>2343 Hayford Road</b>   |  |

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

|                    |  |                       |  |                          |  |                       |  |                      |  |
|--------------------|--|-----------------------|--|--------------------------|--|-----------------------|--|----------------------|--|
| Name of Deceased   |  | Sex                   |  | Age                      |  | Date of Birth         |  | Place of Birth       |  |
| John Doe           |  | Male                  |  | 45                       |  | 10/15/1910            |  | New York, N.Y.       |  |
| Cause of Death     |  | Immediate Cause       |  | Underlying Cause         |  | Contributing Cause    |  | Manner of Death      |  |
| Heart Disease      |  | Myocardial Infarction |  | Coronary Atherosclerosis |  | Hypertension          |  | Natural              |  |
| Date of Death      |  | Time of Death         |  | Place of Death           |  | Physician's Signature |  | Hospital/Institution |  |
| 10/20/1955         |  | 10:15 AM              |  | Home                     |  | [Signature]           |  | St. Mary's Hospital  |  |
| Burial/Disposition |  | Funeral Home          |  | Crematorium              |  | Other                 |  | Remarks              |  |
| Buried             |  | [Signature]           |  | [Signature]              |  | [Signature]           |  | [Signature]          |  |

334

50 5587

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5587

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mae R. Stadler

2. DATE  
OF  
DEATH

June 23 1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF (If not in hospital) or institution, give street address or  
HOSPITAL OR INSTITUTION4204 Loch Raven Blvd  
Northwood Apts. Apt. 4074. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

a. STATE Maryland b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore 27-09

d. STREET ADDRESS (If rural, give location)

4204 Loch Raven Blvd. Apt. 407

5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

female white widow

8. DATE OF BIRTH

Oct. 3, 1882

9. AGE (in years,  
last birthday)

67 yrs.

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10a. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR  
INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Montana

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

David Reinhardt

14. MOTHER'S MAIDEN NAME

Sarah Holland

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Margaret Barker (above)

18. 420.1 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, assthonia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

CORONARY OCCLUSION

1 DAY

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

CEREBRAL THROMBOSIS  
LEFT HEMIPLEGIA

2 YEARS

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

ARTERIOSCLEROTIC CARDIO-  
VASCULAR DISEASE  
DIABETES MELLITUS

5 YEARS

4 YEARS

19a. DATE OF OPERATION

NONE

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21a. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21b. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21e. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from SEPT. 5, 1947 to JUNE 23, 1950, that I last saw the  
deceased alive on JUNE 22, 1950, and that death occurred at 10.30 a.m., from the causes and on the date stated above.

23a. SIGNATURE

Arthur Karpain

23b. ADDRESS

M. D. 4230 Loch Raven Blvd

23c. DATE SIGNED

6-23-50

24a. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24b. DATE

6/26/50

24c. NAME OF CEMETERY OR CREMATORY

Moreland Memorial

24d. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

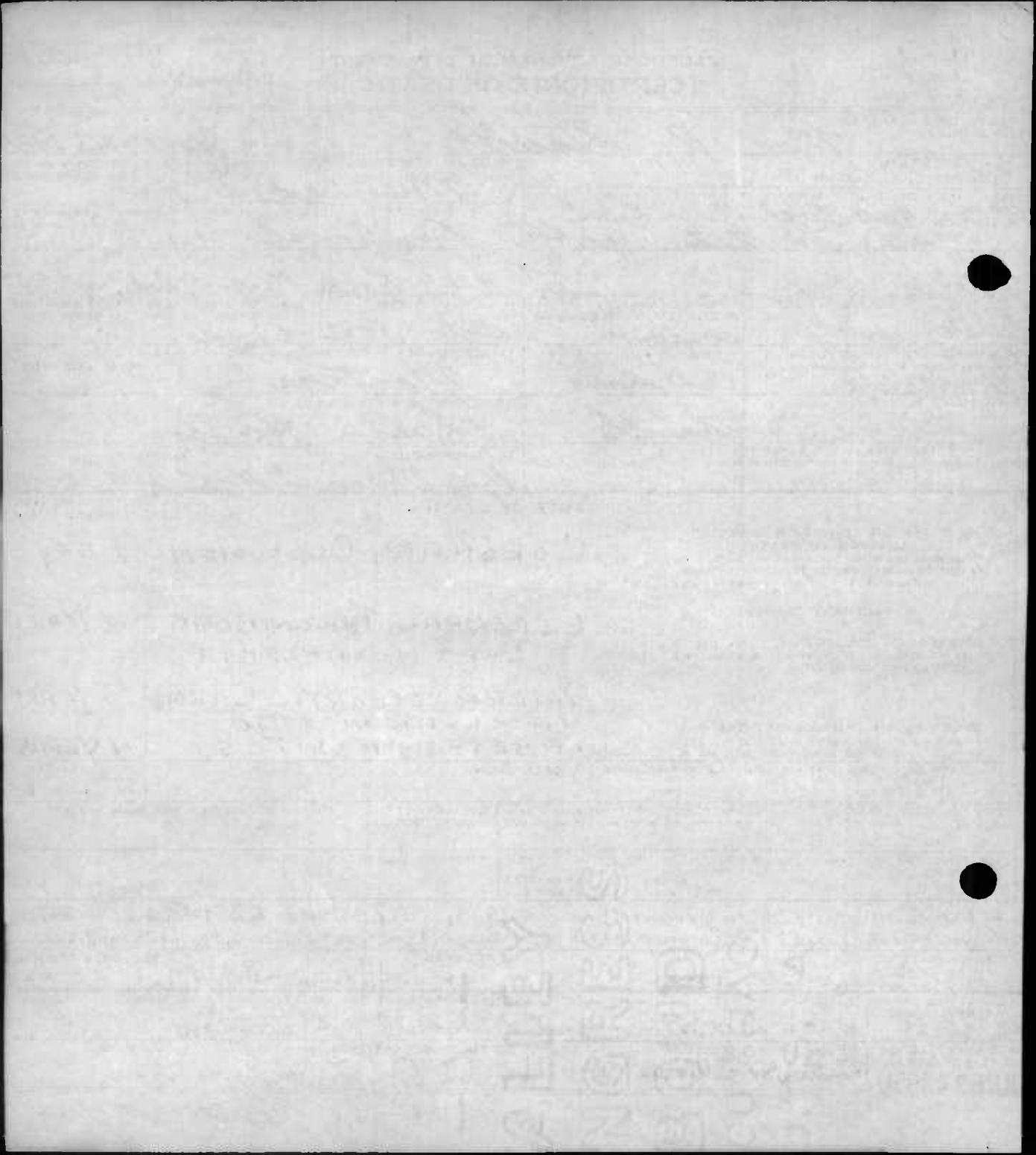
Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Edm. J. Tickner &amp; Sons

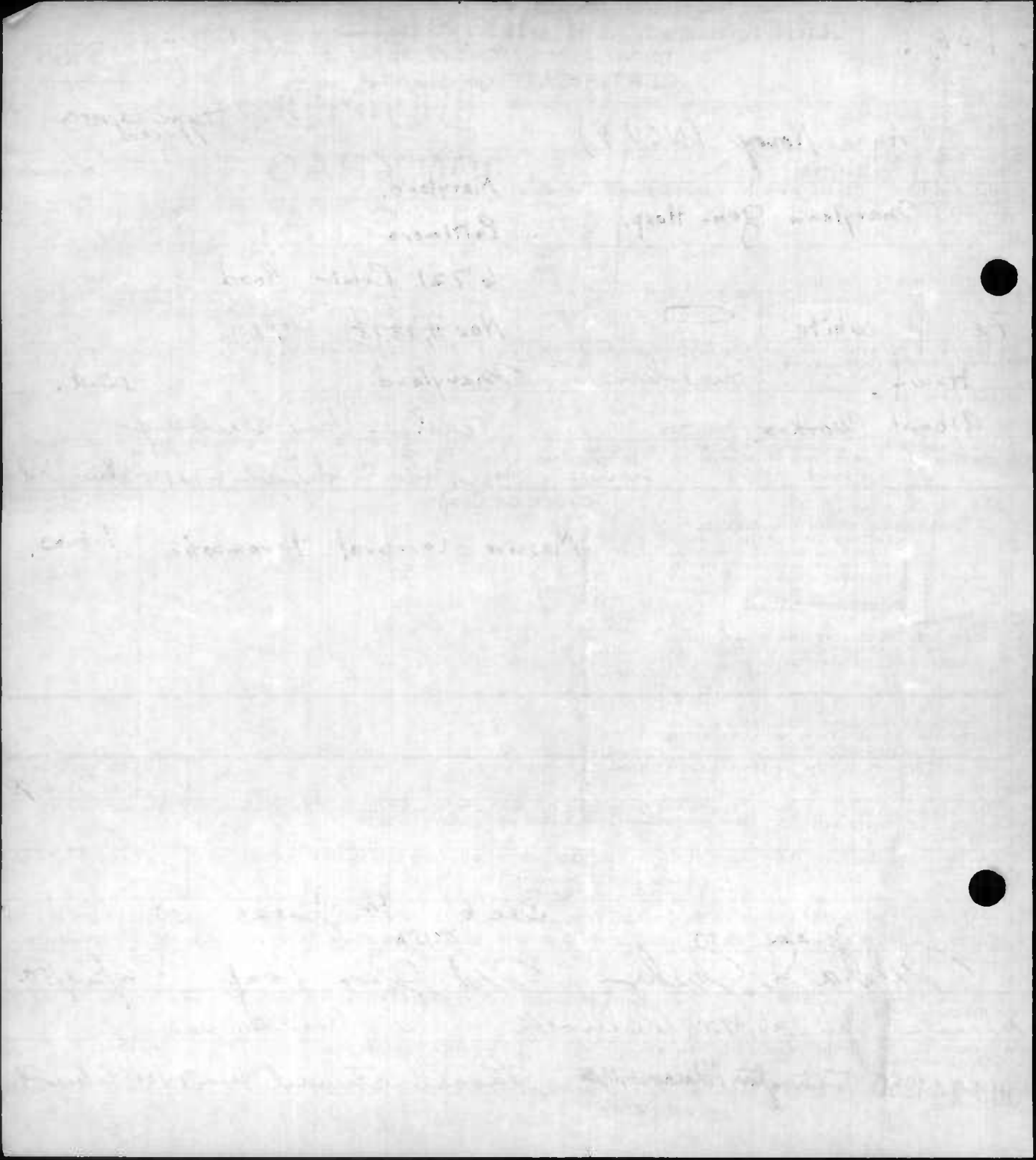
ADDRESS

Balto., Md. 61



| 100<br>50 5588   |  | BIRTH NO.   |  | <div style="display: flex; justify-content: space-between;"> <span>CERTIFICATE CORRECTED</span> <span>6-28-50</span> </div> <div style="display: flex; justify-content: space-between;"> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> <span>X</span> </div> |  | <div style="display: flex; justify-content: space-between;"> <span>50 5588</span> <span>Registered No.</span> </div> |  |
|--|--|---|--|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Anna Nowy (NOU Y)</i>  |  |   |  | 2. DATE OF DEATH<br><i>June 23, 1950</i><br><i>71 years</i>  |  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |  |   |  | 4. USUAL RESIDENCE (Where deceased lived. Institution: residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>  |  |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><i>Maryland Gen. Hosp.</i>   |  |   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore Overlea 5300</i>  |  |  |  |
| D. STREET ADDRESS (If rural, give location)<br><i>6721 Belair Road</i>   |  |   |  | 5. SEX <i>Fe</i> 6. COLOR OR RACE <i>white</i> 7. SINGLE, MARRIED, <del>WIDOWED</del> , DIVORCED (Specify)   |  |  |  |
| 8. DATE OF BIRTH<br><i>10, 1877</i><br><i>Nov 11, 1878</i>   |  |   |  | 9. AGE (In years last birthday) <i>71</i> 10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.   |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Hswf</i>   |  |   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>own house</i>  |  |  |  |
| 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |  |  |
| 13. FATHER'S NAME<br><i>Albert Working Wohnera</i>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><i>Gloise Van Heuberg</i>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>  |  |   |  | 16. SOCIAL SECURITY NO. <i>no</i>  |  |  |  |
| 17. INFORMANT<br><i>Mrs. John C. Lippel</i>  |  |   |  | ADDRESS<br><i>6721 Belair Rd.</i>  |  |  |  |
| 18. <i>332X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Massive Cerebral thrombosis</i> |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>9 mos.</i>  |  |  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B) _____<br>(C) _____   |  |   |  |  |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |   |  |  |  |  |  |
| 19A. DATE OF OPERATION <i>0</i>  |  |   |  | 19B. MAJOR FINDINGS OF OPERATION   |  |  |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |  |  |  |  |
| 21A. ACCIDENT WAS UNDER-<br>LYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)  |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED<br>WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I hereby certify that I attended the deceased from <i>Dec 6, 1950</i> to <i>June 23, 1950</i> that I last saw the deceased alive on <i>June 22, 1950</i> and that death occurred at <i>8:15 Am.</i> , from the causes and on the date stated above.  |  |   |  |  |  |  |  |
| 23A. SIGNATURE<br><i>Eda J. Meyer</i>  |  |   |  | 23B. ADDRESS<br><i>2nd Gen. Hosp.</i>  |  | 23C. DATE SIGNED<br><i>6/23/50</i>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>burial</i>   |  | 24B. DATE<br><i>June 26, 1950</i>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Parkwood</i>  |  | 24D. LOCATION (City, town, or county) (State)<br><i>Balto., Md</i>   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUN 24 1950</i>   |  |   |  | REGISTRAR'S SIGNATURE<br><i>Livingston Williams, M.D.</i>  |  |  |  |
| FUNERAL DIRECTOR<br><i>Laachman Funeral Home</i>   |  |   |  | ADDRESS<br><i>7401 Belair Rd.</i>  |  |  |  |

83B





251

BIRTH NO. 5589

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5589

|  |                               |   |  |   |                                 |
|--|-------------------------------|---|--|---|---------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>ROSENBAUM, BERTHA L.</b>                                       |                               |   | 2. DATE OF DEATH <b>June 23, 1950</b>  |   |                                 |
| 3. PLACE OF DEATH:<br>a. Baltimore City, Maryland  |                               |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>Balto. Md.</b> b. COUNTY <b>13-01</b> |   |                                 |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hospital</b>  |                               |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balto. Md.</b>   |   |                                 |
| 6. Length of stay in Baltimore <b>Lifetime</b>   |                               |   | d. STREET ADDRESS (If rural, give location) <b>Albion Apts Balto. Md.</b>  |   |                                 |
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH <b>May 26, 1872</b>   | 9. AGE (In years last birthday) <b>78</b> | 10. Under 1 Year Months: Days 1 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house</b> |                               |   | 10b. KIND OF BUSINESS OR INDUSTRY  |   |                                 |
| 13. FATHER'S NAME <b>Abraham Selman</b>  |                               |   | 14. MOTHER'S MAIDEN NAME <b>Mina Straus</b>  |   |                                 |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)  |                               |   | 16. SOCIAL SECURITY NO.  |   |                                 |
| 17. INFORMANT <b>Mrs. Susan Rosenfeld</b>  |                               |   | ADDRESS <b>Albion Apts</b>   |   |                                 |

|   |  |  |   |   |  |
|---|--|--|---|---|--|
| 18. <b>154X</b>   |  | CAUSE OF DEATH   |   | INTERVAL BETWEEN ONSET AND DEATH  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   |  | (A) <b>Carcinoma of the rectum</b>                                       |   |   |  |
| ANTECEDENT CAUSES   |  | (B) <b>with metastasis</b>   |   |   |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  | (C) <b>Arteriosclerosis, gen. ASCVD</b>                                  |   |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |  |   |   |  |
| 19a. DATE OF OPERATION <b>June 14, 1950</b>   | 19b. MAJOR FINDINGS OF OPERATION <b>with infiltrating carcinoma of rectum metastasis</b>               |  |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>     |  |
| 20a. ACCIDENT, SUICIDE, HOMICIDE (Specify)  | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |   |  |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY   | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR?   |   |   |  |
| 22. I hereby certify that I attended the deceased from <b>June 5, 1950</b> , to <b>June 23, 1950</b> , that I last saw the deceased alive on <b>June 23, 1950</b> , and that death occurred at <b>3:51 A.M.</b> , from the causes and on the date stated above. |  |  |   |   |  |
| 23a. SIGNATURE <b>B. L. Lason</b>   |  | 23b. ADDRESS <b>Sinai Hospital</b>                                       |   | 23c. DATE SIGNED <b>6.23.50</b>   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)   | 24b. DATE <b>June 25/50</b>  | 24c. NAME OF CEMETERY OR CREMATORY <b>Ches. Shalom</b>                   | 24d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b> |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR <b>JUN 24 1950</b>   |  | REGISTRAR'S SIGNATURE <b>Wilmington Williams, M.D.</b>                   |   | 25. FUNERAL DIRECTOR <b>David Soudaheim</b> ADDRESS <b>1802 Eaton Rd.</b> |  |



FEDERAL BUREAU OF INVESTIGATION  
UNITED STATES DEPARTMENT OF JUSTICE

10-11

10-11-68

326

135977

50 5590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 5590

Registered No.

1. NAME OF DECEASED  
(Type or Print)

Sarah Ann Rodgers

2. DATE OF DEATH

June 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)

Baltimore City Hospitals

4940 Eastern Avenue

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

7. LENGTH OF STAY IN BALTIMORE

Life

8. DATE OF BIRTH

Oct. 28, 1870

9. SEX

Female

10. COLOR OR RACE

Negro

11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

12. AGE (In years last birthday)

79

13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

14. KIND OF BUSINESS OR INDUSTRY

None

15. FATHER'S NAME

Nicholas Cross (D)

16. MOTHER'S MAIDEN NAME

Leneran Dorsey (D)

17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

Yes, no or (unknown)

18. SOCIAL SECURITY NO.

19. INFORMANT

Baltimore City Hospitals

20. ADDRESS

4940 Eastern Avenue

21. CAUSE OF DEATH

18. 332X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebrovascular Thrombosis

DUE TO

ANTECEDENT CAUSES

(B) Cerebral Arteriosclerosis

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic heart disease

22. INTERVAL BETWEEN ONSET AND DEATH

23. DATE OF OPERATION

0

24. MAJOR FINDINGS OF OPERATION

25. AUTOPSY?

YES ☐ NO ☐

26. ACCIDENT WAS UNDER- LYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

27. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

29. TIME (Month) (Day) (Year) (Hour) OF INJURY

30. INJURY OCCURRED

31. HOW DID INJURY OCCUR?

32. I hereby certify that I attended the deceased from Feb. 21, 1950, to June 21, 1950 that I last saw the deceased alive on June 21, 1950, and that death occurred at 5:30 PM, from the causes and on the date stated above.

33. SIGNATURE

R. S. Dozen

M. D.

34. ADDRESS

Baltimore City Hospitals

35. DATE SIGNED

36. BURIAL, CREMATION, REMOVAL (Specify)

Burial

37. DATE

6-25-1950

38. NAME OF CEMETERY OR CREMATORY

St. Thomas

39. LOCATION (City, town, or county) (State)

Randallstown, Md.

40. DATE RECEIVED BY LOCAL REGISTRAR

JUN 24 1950

41. REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

42. FUNERAL DIRECTOR

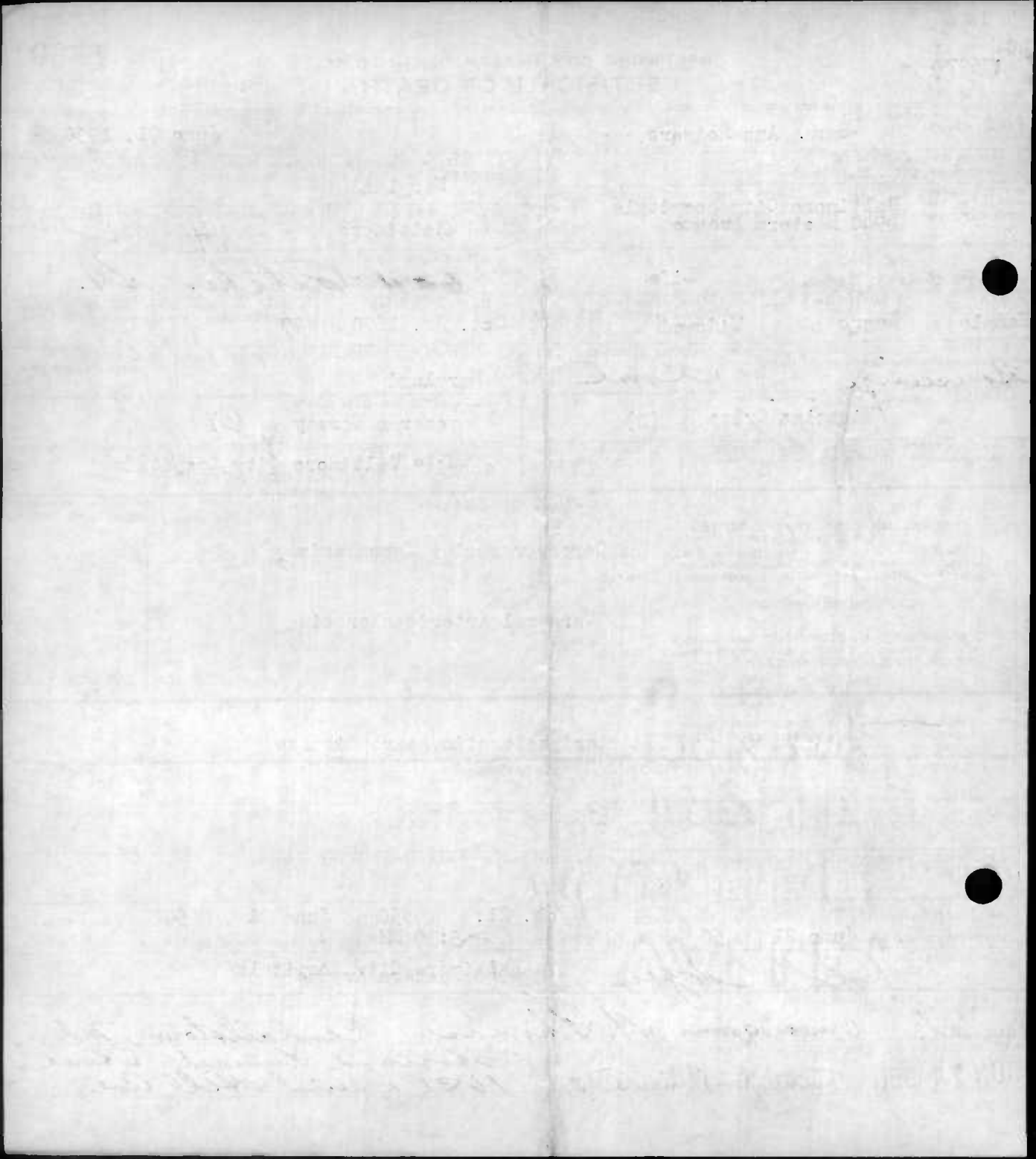
Sholland Funeral Home

43. ADDRESS

1631 Druid Hill Ave.

VS 150

93D



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5591

Registered No.

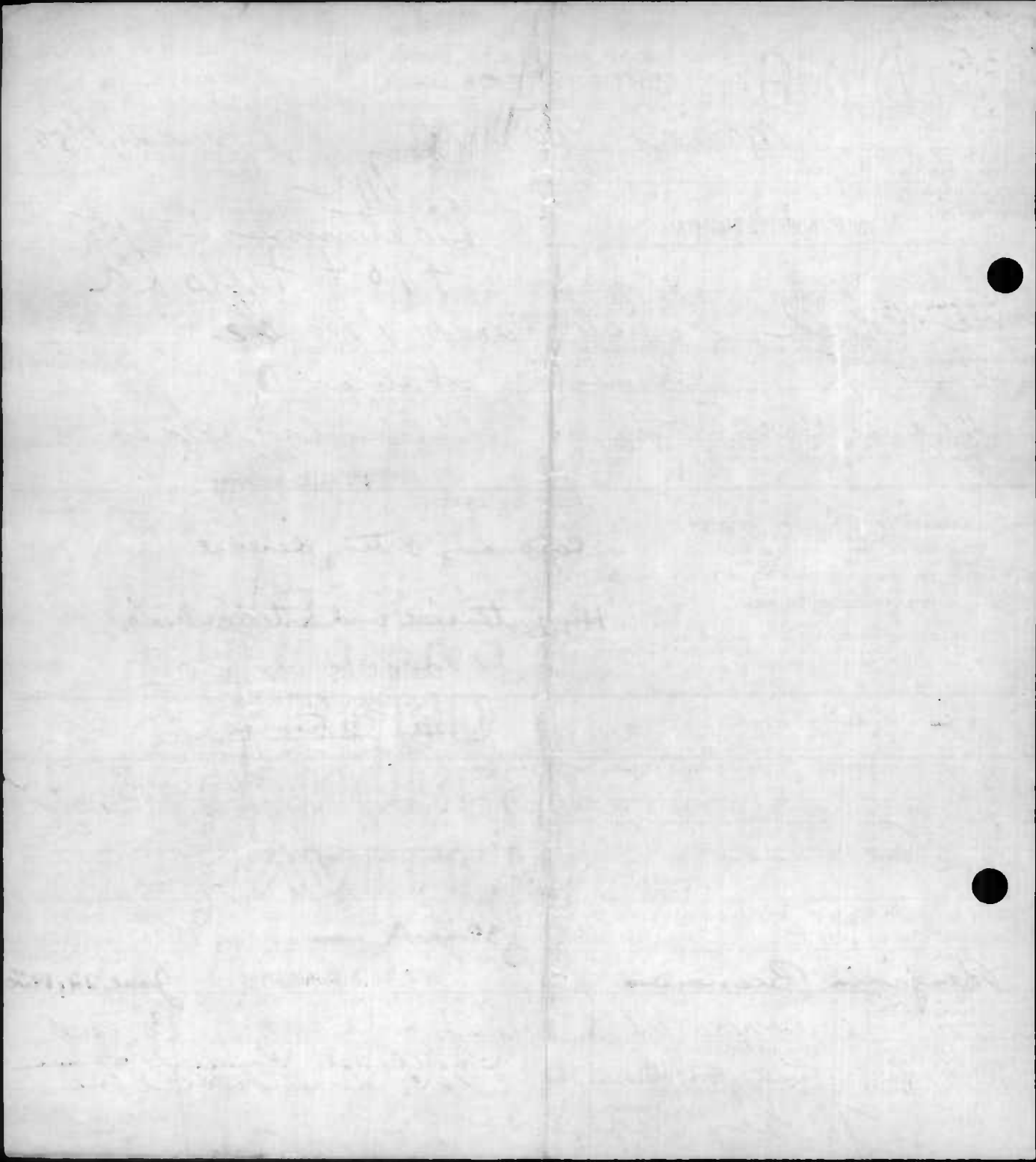
|   |                                    |   |   |
|---|------------------------------------|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Maria Garrett</i>   |                                    | 2. DATE OF DEATH <i>June 21, 1950</i>   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                    | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <i>Md</i> B. COUNTY |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><i>JOHNS HOPKINS HOSPITAL</i> |                                    | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 27-15</i>                |   |
| D. STREET ADDRESS (If rural, give location)<br><i>4704 Falls Rd</i>   |                                    | 5. LENGTH OF STAY IN BALTIMORE<br><i>35 yrs.</i>  |   |
| 5. SEX<br><i>Female</i>   | 6. COLOR OR RACE<br><i>Colored</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Married</i>   | 8. DATE OF BIRTH<br><i>May 17, 1888</i> |
| 9. AGE (in years last birthday)<br><i>62</i>  |                                    | 10. UNDER 1 Year Months: Days   |   |
| 11. UNDER 24 Hours Hours: Min.  |                                    | 12. CITIZEN OF WHAT COUNTRY?  |   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>       |                                    | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>None</i>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><i>Halifax N. Va.</i>  |                                    | 12. CITIZEN OF WHAT COUNTRY?  |   |
| 13. FATHER'S NAME<br><i>Charles Carrington</i>  |                                    | 14. MOTHER'S MAIDEN NAME<br><i>Amanda West</i>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no or unknown) (If yes, give war or dates of service)               |                                    | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><i>JOHNS HOPKINS HOSPITAL</i>  |                                    | ADDRESS   |   |

|  |  |                                  |
|--|--|----------------------------------|
| 18. <i>420.1</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Coronary artery disease</i> |  | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><i>Hypertensive and arteriosclerotic</i>   |  |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |                                  |
| CERTIFICATION APPROVED BY<br>Dr. John R. Davis<br>per: <i>RS Fisher</i> M.D.<br>CHIEF OR ASST. MEDICAL EXAMINER  |  |                                  |

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 19A. DATE OF OPERATION <i>0</i>   |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <i>DOA</i> , 19__, to ____, 19__, that I last saw the deceased alive on <i>DOA</i> , 19__, and that death occurred at <i>DOA</i> m., from the causes and on the date stated above. |  |  |  |   |  |
| 23A. SIGNATURE<br><i>Benjamin Beunives</i> M.D.   |  | 23B. ADDRESS<br><i>JOHNS HOPKINS HOSPITAL</i>  |  | 23C. DATE SIGNED<br><i>June 22, 1950</i>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   |  | 24B. DATE<br><i>6-24-1950</i>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Arbutus Mem. Park</i>                      |  |
| 24D. LOCATION (City, town or county) (State)<br><i>Baltimore Co. Md.</i>  |  | 24E. NAME OF CEMETERY OR CREMATORY<br><i>Arbutus Mem. Park</i>   |  | 24F. LOCATION (City, town or county) (State)<br><i>Baltimore Co. Md.</i>            |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUN 24 1950</i>  |  | REGISTRAR'S SIGNATURE<br><i>Twinington Williams, M.D.</i>  |  | 25. FUNERAL DIRECTOR<br><i>Hallange Funeral Home</i><br><i>1631 Druid Hill Ave.</i> |  |

To be approved

94a



20  
5592

50 5592

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

FREDDIE HARRIES

2. DATE  
OF  
DEATH

June 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

1525 Edmondson Ave.

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

5. SEX

male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

May 3, 1865

9. AGE (in year;  
last birthday)

75

10. Under 1 Year  
Months: Days

11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Porter

10B. KIND OF BUSINESS OR  
INDUSTRY

Dept. Store

11. BIRTHPLACE (State or foreign country)

Matthews W. Va

12. CITIZEN OF  
WHAT COUNTRY?

usa

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS 1525

Mrs. Elizabeth Turner Edmondson Ave

18. 153X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

acute intestinal obstruction

INTERVAL BETWEEN  
ONSET AND DEATH

12 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Carcinoma of Large Intestine

Unknown

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

22. I hereby certify that I attended the deceased from June 21, 1950, to June 22, 1950, that I last saw the deceased alive on June 21, 1950, and that death occurred at 3 P.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

John W. Cairns

M. D.

525 W. Hamburg St

6/23/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial  
DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

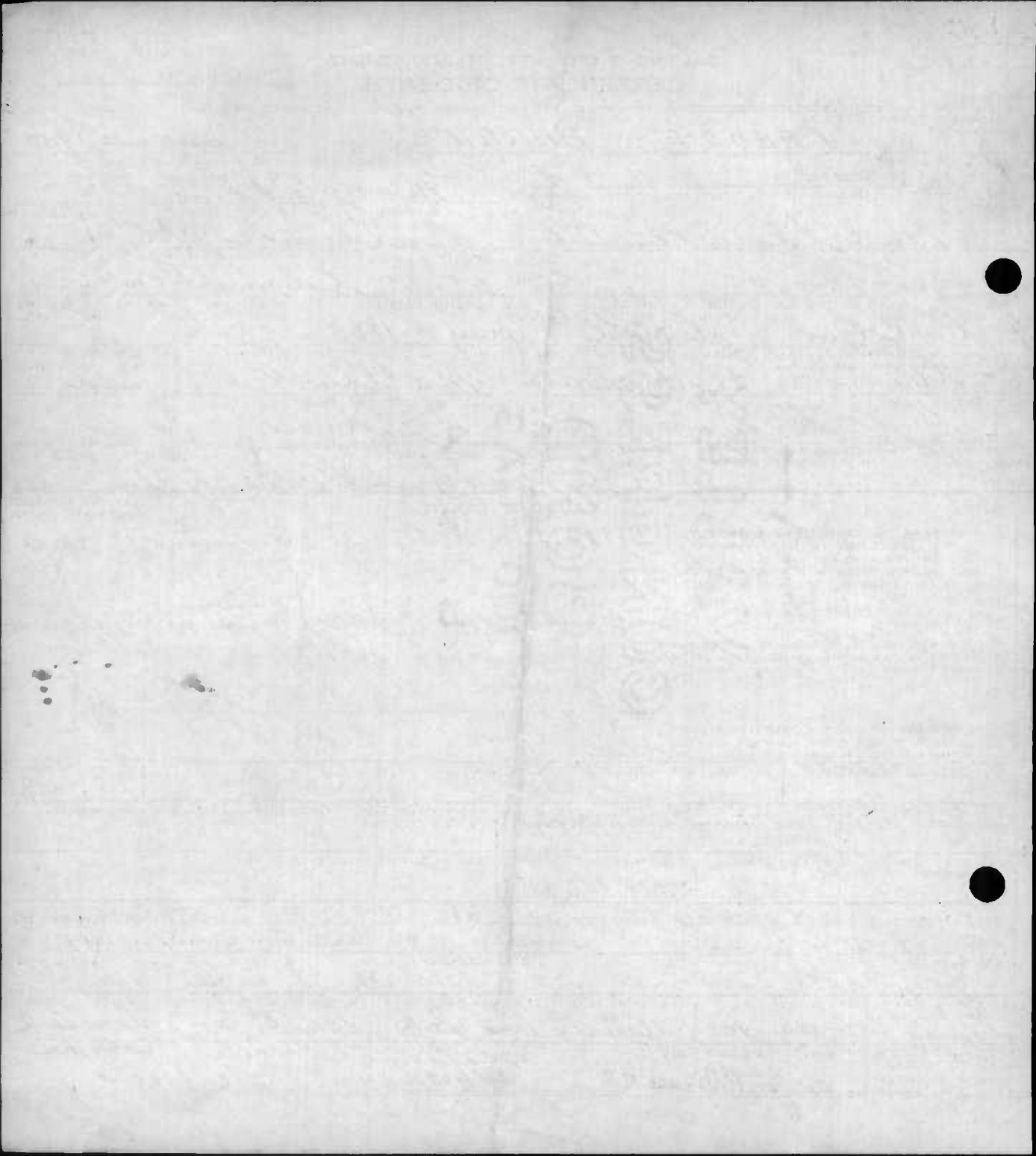
25. FUNERAL DIRECTOR

ADDRESS

JUN 24 1950

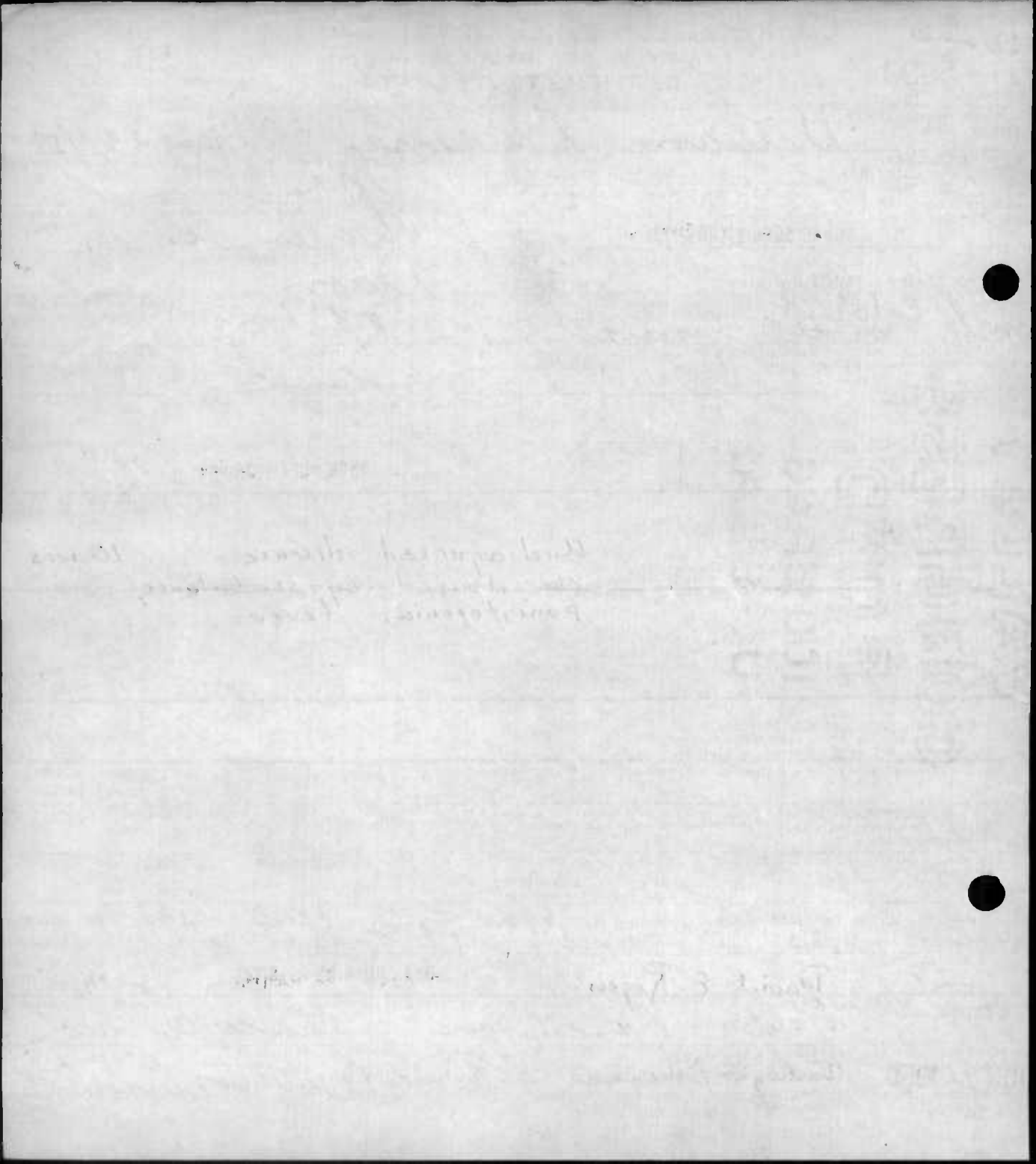
William W. Williams

Funeral  
1634 Squid Hill Ave.





| 525   |  | CERTIFICATE CORRECTED |  | 6-28-50 |  | X  |  | 50 |  | 5593 |  |
|---|--|-----------------------|--|---------|--|--|--|----|--|------|--|
| BALTIMORE CITY HEALTH DEPARTMENT  |  |                       |  |         |  | Registered No.   |  |    |  |      |  |
| BIRTH NO.   |  |                       |  |         |  | 50 5593  |  |    |  |      |  |
| 1. NAME OF DECEASED<br>(Type or Print)  |  |                       |  |         |  | 2. DATE OF DEATH   |  |    |  |      |  |
| William Linkins   |  |                       |  |         |  | June 23, 1950  |  |    |  |      |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |  |                       |  |         |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE B. COUNTY  |  |    |  |      |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>JOHNS HOPKINS HOSPITAL   |  |                       |  |         |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Charles Co.  |  |    |  |      |  |
| D. STREET ADDRESS (If rural, give location)<br>Rison 5800   |  |                       |  |         |  | E. DATE OF BIRTH   |  |    |  |      |  |
| F. AGE (In years last birthday)<br>62   |  |                       |  |         |  | G. Under 1 Year Months Days  |  |    |  |      |  |
| H. Under 24 Hours Hours Min.  |  |                       |  |         |  | I. BIRTHPLACE (State or foreign country)<br>Maryland   |  |    |  |      |  |
| J. CITIZEN OF WHAT COUNTRY?   |  |                       |  |         |  | K. DATE OF DEATH<br>1-2-88   |  |    |  |      |  |
| L. FATHER'S NAME  |  |                       |  |         |  | M. MOTHER'S MAIDEN NAME<br>Nora Summonds   |  |    |  |      |  |
| N. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>Yes, no or unknown   |  |                       |  |         |  | O. SOCIAL SECURITY NO.   |  |    |  |      |  |
| P. 18. 792.4 CAUSE OF DEATH.  |  |                       |  |         |  | Q. INTERVAL BETWEEN ONSET AND DEATH  |  |    |  |      |  |
| R. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>Undiagnosed disease characterized by sombulence, pancytopenia, fever. |  |                       |  |         |  | S. 10 mos.   |  |    |  |      |  |
| T. ANTECEDENT CAUSES  |  |                       |  |         |  | U. DUE TO  |  |    |  |      |  |
| V. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  |                       |  |         |  | W. DUE TO  |  |    |  |      |  |
| X. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |                       |  |         |  | Y. DUE TO  |  |    |  |      |  |
| Z. 19A. DATE OF OPERATION 0   |  |                       |  |         |  | AA. 19B. MAJOR FINDINGS OF OPERATION   |  |    |  |      |  |
| AB. 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |                       |  |         |  | AC. 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |    |  |      |  |
| AD. 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |  |                       |  |         |  | AE. 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)  |  |    |  |      |  |
| AF. 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  |                       |  |         |  | AG. 21E. INJURY OCCURRED<br>WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |    |  |      |  |
| AH. 21F. HOW DID INJURY OCCUR?  |  |                       |  |         |  | AI. 22. I hereby certify that I attended the deceased from 6/2 1950 to 6/23 1950, that I last saw the deceased alive on 6/23 1950, and that death occurred at 8:20 ml, from the causes and on the date stated above. |  |    |  |      |  |
| AJ. 23A. SIGNATURE<br>David E. Rogers M. D.   |  |                       |  |         |  | AK. 23B. ADDRESS<br>JOHNS HOPKINS HOSPITAL   |  |    |  |      |  |
| AL. 23C. DATE SIGNED<br>6-24-50   |  |                       |  |         |  | AM. 24A. BURIAL CREMATION, REMOVAL (Specify)   |  |    |  |      |  |
| AN. 24B. DATE<br>6/26/50  |  |                       |  |         |  | AO. 24C. NAME OF CEMETERY OR CREMATORY<br>Rison, Md.   |  |    |  |      |  |
| AP. 24D. LOCATION (City, town, or county) (State)<br>Charles Co. Md.  |  |                       |  |         |  | AQ. 25. FUNERAL DIRECTOR<br>Barnes & Matthews  |  |    |  |      |  |
| AR. 25. ADDRESS<br>614-4 "St. St."  |  |                       |  |         |  | AS. 26. LOCAL REGISTRATION<br>JUN 24 1950  |  |    |  |      |  |
| AT. 27. REGISTRAR'S SIGNATURE<br>Huntington Williams, M.D.  |  |                       |  |         |  | AU. 28. VS 150   |  |    |  |      |  |
| AV. 29. 98896   |  |                       |  |         |  | AW. 30. 731  |  |    |  |      |  |



S-524  
50 5594BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5594

|   |                                 |   |                                    |
|---|---------------------------------|---|------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>ELLA R. SINGLETON</b>   |                                 | 2. DATE OF DEATH <b>June 23-1950</b>  |                                    |
| 3. PLACE OF DEATH:<br>a. Baltimore City, Maryland   |                                 | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore</b> |                                    |
| b. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>1425 Argyle Ave.</b>  |                                 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 14-02</b>  |                                    |
| c. Length of stay in Baltimore <b>30</b> Yrs. <b>30</b> Mos. <b>30</b> Days                                     |                                 | d. STREET ADDRESS (If rural, give location)<br><b>1425 Argyle Ave</b>   |                                    |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>Colored</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>  | 8. DATE OF BIRTH <b>12/19/1889</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housework</b> |                                 | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Domestic</b>  |                                    |
| 11. BIRTHPLACE (State or foreign country)<br><b>Frederick County, Md</b>  |                                 | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |                                    |
| 13. FATHER'S NAME<br><b>Richard Richardson</b>  |                                 | 14. MOTHER'S MAIDEN NAME<br><b>Rose White</b>   |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>                                     |                                 | 16. SOCIAL SECURITY NO. <b>no</b>   |                                    |
| 17. INFORMANT <b>Mrs. Olive D. R. Rithland, Pa.</b>   |                                 | ADDRESS   |                                    |

|   |  |  |
|---|--|--|
| 1b. <b>4 yr. 1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cardio Vascular Disease</b><br>DUE TO<br><b>Broken Compensation</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yrs.</b><br><b>6 months</b> |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |  |

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 19a. DATE OF OPERATION <b>0</b>  |  | 19b. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |  | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21d. TIME (Month) (Day) (Year) (Hour) <b>INJURY</b>  |  | 21e. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <b>June 3</b> 1950, to <b>June 23</b> , 1950, that I last saw the deceased alive on <b>June 21</b> , 1950, and that death occurred at <b>5:40</b> p.m., from the causes and on the date stated above. |  |   |  |  |  |
| 23a. SIGNATURE<br><b>E. William Frey</b> M. D.   |  | 23b. ADDRESS<br><b>1928 Penna. av</b>   |  | 23c. DATE SIGNED<br><b>6/23/50</b>                                       |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 24b. DATE<br><b>6/26/50</b>   |  | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Edwards Ave. Edmonds, Md.</b>   |  |
| 24d. LOCATION (City, town, or county) (State)  |  | 24e. DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 25 1950</b>   |  | 24f. REGISTRAR'S SIGNATURE<br><b>Livingston Williams, M.D.</b>           |  |
| 24g. FUNERAL DIRECTOR<br><b>32086 Woodboro, Maryland</b>   |  | 24h. ADDRESS<br><b>937</b>  |  | 24i. DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 25 1950</b>              |  |

CERTIFICATE OF DEATH

STATE OF NEW YORK

County of \_\_\_\_\_

City of \_\_\_\_\_

19\_\_\_\_

Month of \_\_\_\_\_

Day of \_\_\_\_\_

Hour of \_\_\_\_\_

Minute of \_\_\_\_\_

Second of \_\_\_\_\_

Year of \_\_\_\_\_

Month of \_\_\_\_\_

Day of \_\_\_\_\_

Hour of \_\_\_\_\_

Minute of \_\_\_\_\_

Second of \_\_\_\_\_

Year of \_\_\_\_\_

Month of \_\_\_\_\_

Day of \_\_\_\_\_

Hour of \_\_\_\_\_

Minute of \_\_\_\_\_

Second of \_\_\_\_\_

Year of \_\_\_\_\_

Month of \_\_\_\_\_

Day of \_\_\_\_\_

Hour of \_\_\_\_\_

Minute of \_\_\_\_\_

Second of \_\_\_\_\_

Year of \_\_\_\_\_

Month of \_\_\_\_\_

Day of \_\_\_\_\_

Hour of \_\_\_\_\_

Minute of \_\_\_\_\_

Second of \_\_\_\_\_

Year of \_\_\_\_\_

Month of \_\_\_\_\_

Day of \_\_\_\_\_

Hour of \_\_\_\_\_

Minute of \_\_\_\_\_

Second of \_\_\_\_\_

Year of \_\_\_\_\_

Month of \_\_\_\_\_

Day of \_\_\_\_\_

Hour of \_\_\_\_\_

Minute of \_\_\_\_\_

Second of \_\_\_\_\_

Year of \_\_\_\_\_

R-400  
50 5595

50 5595

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

|   |                                  |  |                                      |   |                                  |
|---|----------------------------------|--|--------------------------------------|---|----------------------------------|
| BIRTH NO.   |                                  | 1. NAME OF DECEASED<br>(Type or Print) <b>Irene B. Reilly</b>  |                                      | 2. DATE OF DEATH <b>6-22-50</b>   |                                  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>Baltimore</b>  |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |                                      |   |                                  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>504 Harwood Ave.</b>   |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 27-48</b>                         |                                      |   |                                  |
| Length of stay in Baltimore <b>Life</b>   |                                  | D. STREET ADDRESS (If rural, give location)<br><b>504 Harwood Ave.</b>   |                                      |   |                                  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b>  | 8. DATE OF BIRTH<br><b>11-9-1871</b> | 9. AGE (In years last birthday)<br><b>78</b>  | 10. Under 1 Year<br>Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |                                      | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                        |                                  |
| 13. FATHER'S NAME<br><b>William W. Dorrett</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Laura Jones</b>   |                                      |   |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)   |                                  | 16. SOCIAL SECURITY NO.  |                                      | 17. INFORMANT ADDRESS <b>407</b><br><b>Mrs. Charles F. Longley, Chartr Oak Ave.</b> |                                  |

|   |  |  |
|---|--|--|
| 18. <b>422.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic Cardio-Vascular Disease.</b><br>DUE TO (A)                                    | CAUSE OF DEATH<br><b>Arteriosclerotic Cardio-Vascular Disease.</b> | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 yrs.</b> |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>Cerebral Sclerosis with Schility</b><br>DUE TO (C) |  |  |

|  |   |   |
|--|---|---|
| 19A. DATE OF OPERATION <b>0</b>              | 19B. MAJOR FINDINGS OF OPERATION  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |

22. I hereby certify that I attended the deceased from **24 May** 19**46**, to **June**, 19**50**, that I last saw the deceased alive on **June 20**, 19**50**, and that death occurred at **11 A.** m., from the causes and on the date stated above.

|   |  |  |
|---|--|--|
| 23A. SIGNATURE<br><b>Wm. H. Kammner</b> | 23B. ADDRESS<br><b>501 Sheridan Ave.</b> | 23C. DATE SIGNED<br><b>June 23, 1950</b> |
|---|--|--|

|  |                             |  |   |
|--|-----------------------------|--|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24B. DATE<br><b>6-26-50</b> | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b> | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Md.</b> |
|--|-----------------------------|--|---|

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| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 25 1950</b> | REGISTRAR'S SIGNATURE<br><b>Christington Williams, M.D.</b> | 25. FUNERAL DIRECTOR<br><b>John H. Moran</b> | ADDRESS<br><b>3000 E. Baltimore St.</b> |
|--|---|--|---|

INSTITUTE OF HEALTH INVESTIGATION  
CERTIFICATE OF DEATH

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R-235  
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50 5596

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

|  |                                  |  |  |   |   |
|--|----------------------------------|--|--|---|---|
| BIRTH NO.  |                                  | 1. NAME OF DECEASED<br>(Type or Print) <i>St. M. Philiberta Recktenwald</i>  |  | 2. DATE OF DEATH<br><i>June 24,</i>                               |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> |  |   |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><i>Notre Dame of Md.</i> |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 27-11</i>                                       |  |   |   |
| D. STREET ADDRESS (If rural, give location)<br><i>4701 North Charles Street</i>                                  |                                  | 5. LENGTH OF STAY IN BALTIMORE <i>67 yts.</i>  |  |   |   |
| 5. SEX<br><i>Female</i>  | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Single</i>   | 8. DATE OF BIRTH<br><i>Feb. 15, 1860</i> | 9. AGE (In years last birthday)<br><i>90</i>                      | 10. Under 1 Year<br>Months: <i>4</i> Days: <i>9</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Teacher</i>    |                                  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><i>Buffalo, N.Y.</i> |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |                                  | 13. FATHER'S NAME<br><i>Nicolaus Recktenwald</i>   |  | 14. MOTHER'S MAIDEN NAME<br><i>Elizabeth Schmdier</i>             |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)          |                                  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><i>St. M. Petet Fourier</i>                      |   |

|  |  |   |  |   |
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| 18. <i>470.1</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Coronary Thrombosis</i> |  | CAUSE OF DEATH<br>(A) <i>Coronary Thrombosis</i><br>DUE TO                    |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>1 hr</i> |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE. (A) STATING THE UNDERLYING CONDITION LAST.<br><i>Arterio-sclerosis - Heart</i>  |  | (B) <i>Arterio-sclerosis - Heart</i><br>DUE TO<br><i>hyp - 3 yrs duration</i> |  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  | (C)   |  |   |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 19A. DATE OF OPERATION<br><i>None</i>   |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <i>1947</i> , 19 <i>6/24</i> , 19 <i>50</i> that I last saw the deceased alive on <i>6/24</i> , 19 <i>50</i> and that death occurred at <i>6/24</i> , 19 <i>50</i> from the causes and on the date stated above. |  |   |  |  |  |

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| 23A. SIGNATURE<br><i>Frank C. Fourier</i>                         |  | 23B. ADDRESS<br><i>1129 St. Paul</i>         |  | 23C. DATE SIGNED<br><i>June 24/50</i>                              |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)                         |  | 24B. DATE<br><i>June 26/50</i>               |  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Charles M. Charles M.</i> |  |
| 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore</i> |  | 24E. FUNERAL DIRECTOR<br><i>Geo M. Smith</i> |  | 24F. ADDRESS<br><i>1129 St. Paul</i>                               |  |

JUN 25 1950  
VS-150

94a



CERTIFICATE OF DEATH

1911

IN THE DISTRICT OF COLUMBIA

WILLIAM HENRY HARRIS

1871

WHITE

Male

Single

Married

Widowed

Divorced

Never married

Married

Widowed

Divorced

Never married

Married

Widowed

Divorced

Never married

Married

Widowed

Divorced

Never married

Med - Exam Case

Released to 50 5597  
H-322BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHX 50 5597  
Registered No.

|  |                                  |   |  |   |   |
|--|----------------------------------|---|--|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Sammie Hodges</i>  |                                  |   | 2. DATE OF DEATH<br><i>June 24, 1950</i>   |   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>Hal 3 bldg - 404</i>                                |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Mo.</i> B. COUNTY <i>V-22</i> |   |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>JOHNS HOPKINS HOSPITAL</i>                                 |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Kansas City</i>                                 |   |   |
| D. STREET ADDRESS (If rural, give location)<br><i>2452 Astor St</i>                                      |                                  |   | E. LENGTH OF STAY IN BALTIMORE<br><i>Yrs. Mos. Days</i>  |   |   |
| 5. SEX<br><i>Female</i>  | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Child</i> | B. DATE OF BIRTH<br><i>11-25-46</i>  | 9. AGE (in years last birthday)<br><i>3</i> | H Under 1 Year Months: Days<br><i>6</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)              |                                  |   | 10B. KIND OF BUSINESS OR INDUSTRY  |   |   |
| 13. FATHER'S NAME<br><i>Kenneth Hodges</i>   |                                  |   | 14. MOTHER'S MAIDEN NAME   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) |                                  |   | 16. SOCIAL SECURITY NO.  |   |   |
| 17. INFORMANT<br><i>JOHNS HOPKINS HOSPITAL</i>   |                                  |   | ADDRESS  |   |   |

|   |   |                                  |
|---|---|----------------------------------|
| 18. 754.4<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | CAUSE OF DEATH<br><i>Cardiac Arrest during Operation for Congenital Heart Disease</i><br>(A) DUE TO<br>(B) DUE TO<br>(C) DUE TO | INTERVAL BETWEEN ONSET AND DEATH |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |   |                                  |

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| 19A. DATE OF OPERATION<br><i>6/24/50</i>   | 19B. MAJOR FINDINGS OF OPERATION<br><i>Pulmonic Stenosis</i>   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |
| 22. I hereby certify that I attended the deceased from <i>6-16-1950</i> to <i>6-24-1950</i> that I last saw the deceased alive on <i>6-24-1950</i> and that death occurred at <i>9:00 a.m.</i> from the causes and on the date stated above. |  |   |
| 23A. SIGNATURE<br><i>JNP Johns</i><br>M. D.  | 23B. ADDRESS<br><i>JOHNS HOPKINS HOSPITAL</i>  | 23C. DATE SIGNED<br><i>6/24/50</i>  |

|   |   |   |   |
|---|---|---|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>shipment &amp; burial</i> | 24B. DATE<br><i>6/24/50</i>                               | 24C. NAME OF CEMETERY OR CREMATORY  | 24D. LOCATION (City, town, or county) (State)<br><i>Kansas City, Missouri</i> |
| DATE RECEIVED BY LOCAL REGISTRAR  | REGISTRAR'S SIGNATURE<br><i>Wilmington Williams, M.D.</i> | 25. FUNERAL DIRECTOR<br><i>John O. Mitchell &amp; Sons, Inc. - 1900 Eutaw Pl.</i><br>ADDRESS<br><i>John O. Mitchell</i> |   |

JUN 25 1950

To be appror. by Med Exam

157E

Cardiac Arrest during  
Operation for  
Cerebral Aneurysm  
Dissect

6/24/20 Pulmonary Stenosis X

6/24/20

2499 Jones



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H-655  
50 5599BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5599  
Registered No.

|   |                              |   |                  |   |  |
|---|------------------------------|---|------------------|---|--|
| BIRTH NO.   |                              | 1. NAME OF DECEASED<br>(Type or Print) <b>JULIUS HERMAN</b>   |                  | 2. DATE OF DEATH <b>JUNE 24 1950</b>  |  |
| 3. PLACE OF DEATH:<br>a. Baltimore City, Maryland   |                              | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>a. STATE <b>Md</b> b. COUNTY |                  |   |  |
| b. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>WEST BALTO. GEN. HOSP</b>   |                              | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 13-02</b>                |                  |   |  |
| c. Length of stay in Baltimore  |                              | d. STREET ADDRESS (If rural, give location)<br><b>2101 Galloway Ave</b>   |                  |   |  |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. SINGLE <input checked="" type="checkbox"/> MARRIED<br>WIDOWED, DIVORCED (Specify)                                  | 8. DATE OF BIRTH | 9. AGE (in years last birthday)<br><b>33</b>  | If Under 1 Year Months: Days If Under 24 Hours Hours: Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)   |                              | 10b. KIND OF BUSINESS OR INDUSTRY   |                  | 11. BIRTHPLACE (State or foreign country)   |  |
| <b>Insurance Agent</b>  |                              |   |                  | <b>St Marys County Md</b>   |  |
| 13. FATHER'S NAME<br><b>Philip</b>  |                              | 14. MOTHER'S MAIDEN NAME<br><b>Belia</b>  |                  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)   |                              | 16. SOCIAL SECURITY NO.   |                  | 17. INFORMANT<br><b>Shirley Herman</b> ADDRESS<br><b>Same</b>                       |  |
| 18. <b>420.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Acute Myocardial Infarction</b><br>DUE TO<br><b>HASCD</b><br>DUE TO<br><b>Diabetes Mellitus</b> |                              | INTERVAL BETWEEN ONSET AND DEATH  |                  |   |  |
| 19a. DATE OF OPERATION <b>0</b>   |                              | 19b. MAJOR FINDINGS OF OPERATION  |                  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                              | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                             |                  | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21d. TIME (Month) (Day) (Year) (Hour)<br>INJURY   |                              | 21e. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>             |                  | 21f. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>June 23, 1950</b> , to <b>June 24, 1950</b> , that I last saw the deceased alive on <b>June 24, 1950</b> , and that death occurred at <b>7:30</b> p. m., from the causes and on the date stated above.  |                              |   |                  |   |  |
| 23a. SIGNATURE<br><b>W. B. Smith</b>  |                              | 23b. ADDRESS<br><b>W. B. Smith</b>  |                  | 23c. DATE SIGNED<br><b>6/24/50</b>  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                              | 24b. DATE<br><b>6-25-50</b>   |                  | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Rosedale</b>                               |  |
| 24d. LOCATION (City, town, or county)<br><b>Balto Md</b>  |                              | 25. FUNERAL DIRECTOR<br><b>Jack Henry</b> ADDRESS<br><b>2100 Cutaw Rd</b>   |                  |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 25 1950</b>  |                              | REGISTRAR'S SIGNATURE<br><b>W. B. Smith</b>   |                  |   |  |

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W-522  
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50 5600

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

|   |                                  |   |  |  |  |
|---|----------------------------------|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>SOPHIA WANCOWICZ</b>  |                                  |   | 2. DATE OF DEATH <b>June 22, 1950</b>  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY _____ |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>127 N. Ellwood Avenue</b>  |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>6-01</b>                         |  |  |
| C. Length of stay in Baltimore <b>45 yrs.</b><br>Yrs. _____<br>Mos. _____<br>Days _____                               |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>127 N. Ellwood Avenue</b>  |  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b> | B. DATE OF BIRTH<br><b>11/25/1888</b>  |  | 9. AGE (In years last birthday) <b>61</b><br>If Under 1 Year: Months _____ Days _____<br>If Under 24 Hours: Hours _____ Min. _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Household</b>       |                                  | 10B. KIND OF BUSINESS OR INDUSTRY _____                           | 11. BIRTHPLACE (State or foreign country)<br><b>Poland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |
| 13. FATHER'S NAME<br><b>Stanislaus Zak</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Anna Michno</b>   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b> |                                  | 16. SOCIAL SECURITY NO. _____                                     | 17. INFORMANT ADDRESS<br><b>Joseph Wancowicz, 3003 Hudson Street</b>   |  |  |

|  |  |                                |   |
|--|--|--------------------------------|---|
| 18. <b>4 yrs. 1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerosis C. V. Disease.</b> |  | CAUSE OF DEATH                 | INTERVAL BETWEEN ONSET AND DEATH<br><b>Feb 6/50</b> |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Chronic hypertension</b>  |  | (B) <b>Independent Failure</b> | <b>Feb 6/50</b>                                     |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>None</b>   |  | (C) <b>None</b>                | <b>6-16-50</b>                                      |

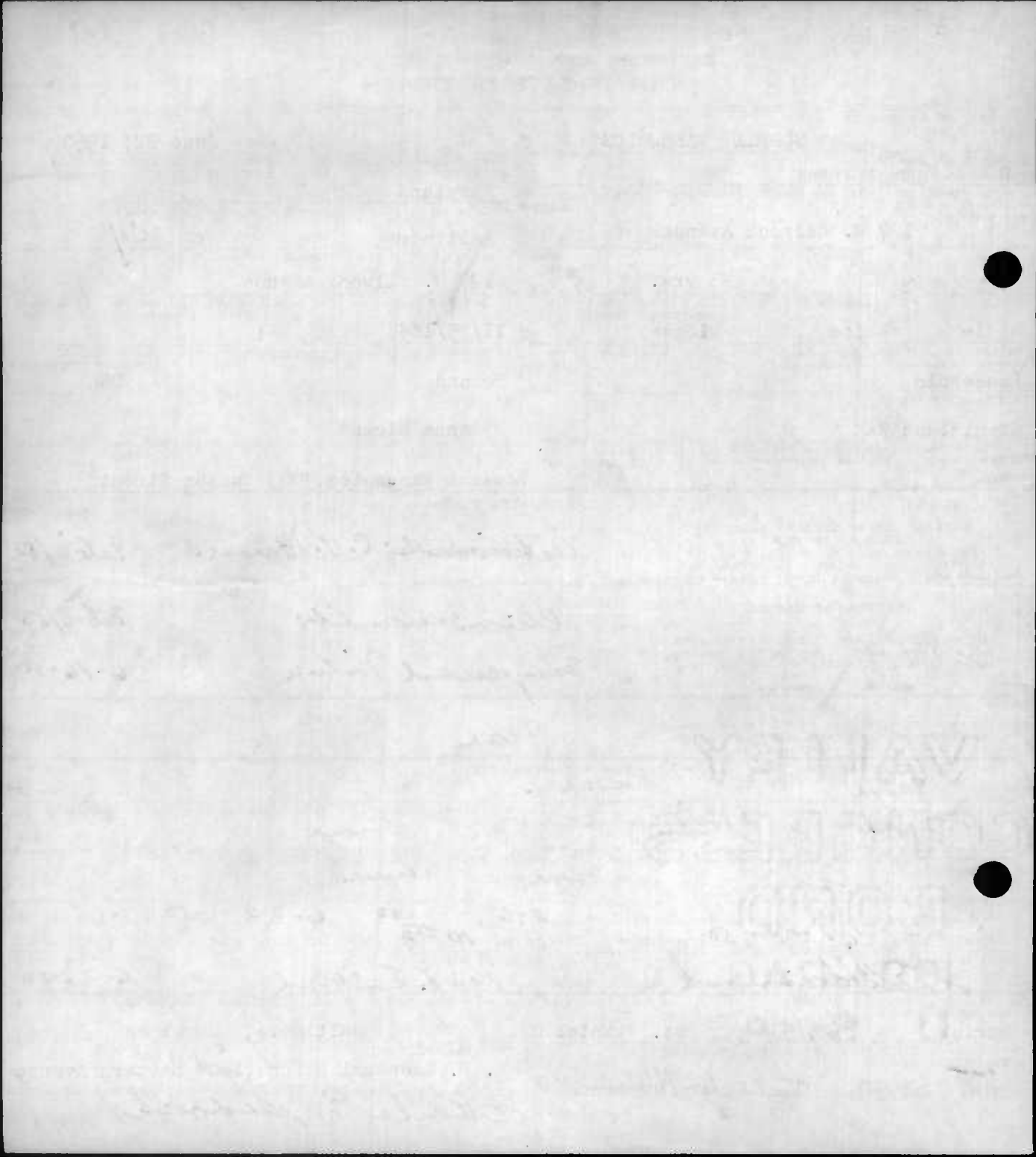
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|---|--|--|---|---|--|
| 19A. DATE OF OPERATION <b>None</b>  |  | 19B. MAJOR FINDINGS OF OPERATION <b>None</b> |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDER-<br>LYING <input type="checkbox"/> PERSON CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br><b>None</b>                           |  | 21C. WHERE DID (If in Baltimore City, give exact location)<br>INJURY OCCUR? <b>None</b> |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>INJURY <b>None</b>   | 21E. INJURY OCCURRED<br>WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?<br><b>None</b>   |   |  |

22. I hereby certify that I attended the deceased from **2-6** 19**50**, to **6-22**, 19**50**, that I last saw the deceased alive on **6-22**, 19**50**, and that death occurred at **10 45** a.m., from the causes and on the date stated above.

|  |                             |   |  |                                    |
|--|-----------------------------|---|--|------------------------------------|
| 23A. SIGNATURE<br><b>S. Scheinman</b>                      |                             | M. O. <b>MD</b>   | 23B. ADDRESS<br><b>842 E. East Ave</b>                                     | 23C. DATE SIGNED<br><b>6-23-50</b> |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24B. DATE<br><b>6/26/50</b> | 24C. NAME OF CEMETERY OR CREMATORY<br><b>St. Stanislaus</b> | 24D. LOCATION (City, town or county) (State)<br><b>Baltimore, Maryland</b> |                                    |

|  |   |   |
|--|---|---|
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 25 1950</b><br>VS 150 | REGISTRAR'S SIGNATURE<br><b>Antony Williams, MD</b> | 25. FUNERAL DIRECTOR ADDRESS<br><b>M. F. Sadowski &amp; Sons, 1808 Eastern Avenue</b><br><b>Charles W. Sadowski 937</b> |
|--|---|---|

MEDICAL CERTIFICATION



C-455  
50 5601BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5601  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Laura Coleman

2. DATE  
OF  
DEATH

6/23/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

15-09

D. STREET ADDRESS (If rural, give location)

2810 Chelsea Terrace #16

Length of stay in Baltimore

40

Yrs  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

2-5-1888

9. AGE (In years  
last birthday)

62

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

William A. Chapline

14. MOTHER'S MAIDEN NAME

Ida M. Cookus

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

William J. Coleman, Jr. as above

18. 204.0

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Chronic lymphatic leukemia

DUE TO

with anasarca  
anemiaINTERVAL BETWEEN  
ONSET AND DEATH

overlyr

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Hypertensive cardiovascular disease

unknown

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT

NOT WHILE

m.

WORK

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-22, 1950, to 6-23, 1950, that I last saw the  
deceased alive on 6/23, 1950, and that death occurred at 9:23 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Marguerite Louise Carder

M. D.

23B. ADDRESS

Maryland General Hospital

23C. DATE SIGNED

6/23/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

6/26/50

24C. NAME OF CEMETERY OR CREMATORY

Cheswood Cent

24D. LOCATION (City, town, or county)

Shepherdstown W. Va

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, III

25. FUNERAL DIRECTOR

ADDRESS

Barney H. Metzger 4101 Camden

74a ave

100-10

100-10

100-10

100-10

100-10

100-10

100-10

100-10

100-10

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100-10

Registered No. \_\_\_\_\_

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

2. DATE OF DEATH June 27, 1950

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

8. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

Maryland Baltimore  
C. CITY OR TOWN (If outside corporate limits, write RURAL and give

Church Home & Hosp.

Baltimore 7 15-07A

c. Length of stay in Baltimore 41

D. STREET ADDRESS (If rural, give location) 3315 Fairview Ave.

|             |                       |  |
|-------------|-----------------------|--|
| 5. SEX<br>F | 6. COLOR OR RACE<br>W | 7. SINGLE, MARRIED,<br>WIDOWED, DIVORCED (Specify) |
|-------------|-----------------------|--|

|                  |                                 |                                  |                                  |
|------------------|---------------------------------|----------------------------------|----------------------------------|
| 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Year<br>Months: Days | 11. Under 24 Hours<br>Hours: Min |
|------------------|---------------------------------|----------------------------------|----------------------------------|

|   |       |         |
|---|-------|---------|
| Female  | White | Widowed |
| 10A. USUAL OCCUPATION (GIVE NAME OF FIRM IF EMPLOYED) |       |         |

Aug. 23, 1876 75

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

11. BIRTHPLACE (State or foreign country)  
12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME 2014 F D Home

14. MOTHER'S MAIDEN NAME

Smith, Mr. Thomas

Fried. Cone

|  |                         |
|--|-------------------------|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no or unknown) | 16. SOCIAL SECURITY NO. |
|--|-------------------------|

17. INFORMANT *W. J. ...* ADDRESS *Jamien*

18. 570.5 I  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

|                |               |                                  |
|----------------|---------------|----------------------------------|
| CAUSE OF DEATH |               | INTERVAL BETWEEN ONSET AND DEATH |
| (A)            | <i>Uremia</i> | <i>Weeks</i>                     |

### ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Maximum Characterization Score

11

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

|                             |                                  |   |
|-----------------------------|----------------------------------|---|
| 19A. DATE OF OPERATION<br>7 | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|-----------------------------|----------------------------------|---|

|  |   |  |
|--|---|--|
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|--|---|--|

|                                       |   |                            |
|---------------------------------------|---|----------------------------|
| 21D. TIME (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED  | 21F. HOW DID INJURY OCCUR? |
| INJURY<br>m.                          | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |                            |

22. I hereby certify that I attended the deceased from June 19, 1950, to June 23, 1950, that I last saw the deceased alive on June 23, 1950 and that death occurred at 3:20 p.m., from the causes and on the date stated above.

|  |   |                                    |
|--|---|------------------------------------|
| 23A. SIGNATURE<br><i>Robert E. Crook</i> | 23B. ADDRESS<br><i>Church Home Shop</i> | 23C. DATE SIGNED<br><i>6/28/70</i> |
|--|---|------------------------------------|

|   |           |                                    |   |
|---|-----------|------------------------------------|---|
| A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
| 1. Burial                               | 11-23-66  | W. 13                              | B. 13   |

|                                   |                       |                      |           |
|-----------------------------------|-----------------------|----------------------|-----------|
| DATE RECEIVED BY<br>CAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS   |
| June 26, 58                       | [Signature]           | [Signature]          | [Address] |

JUN 26 1950 *Spring Byers 5005 FR. 1410 to*

1222

June 23 1925

Dear Mr. Bennett

I have been thinking of you

very much lately

and wondering how you

are getting on

and what you are doing

now

I hope you are well

and happy

and that you are

doing well

I am, yours truly,

W. B. E. Bennett

13357



| 623<br>50 5603  |                            | CERTIFICATE CORRECTED 8-2-50  |  | 50 5603  |  |
|---|----------------------------|---|--|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT  |                            |   |  | Registered No.   |  |
| BIRTH NO.   |                            |   |  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Edward Lee Crist</u>  |                            |   | 2. DATE OF DEATH <u>6/24/50</u>  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <u>3501 W. Rogers Ave</u>   |                            |   | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>Md</u> B. COUNTY <u>Balto</u> |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION   |                            |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><u>Baltimore</u> <u>27-17</u>                      |  |  |
| C. Month of stay in Baltimore   |                            |   | D. STREET ADDRESS (If rural, give location)<br><u>3501 W. Rogers Ave</u>   |  |  |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W.</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>W.</u>   | 8. DATE OF BIRTH <u>April 8, 1862</u>  | 9. AGE (In years, last birthday) <u>88</u>                               | 10. Under 1 Year Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired Farmer</u>  |                            | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Farmer</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Frederick Co. Md</u>     |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |                            |   | 13. FATHER'S NAME<br><u>Drafton Crist</u>  |  |  |
| 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>  |                            |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)  |  |  |
| 16. SOCIAL SECURITY NO.   |                            |   | 17. INFORMANT ADDRESS<br><u>Mrs. Herbert Ridgely 3501 W. Rogers Ave</u>  |  |  |
| 18. 422.1<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>DUE TO <u>Arteriosclerotic Cardio-vascular disease</u> |                            |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>?</u>   |  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B) <u>Generalized Arteriosclerosis</u><br>DUE TO <u>?</u>  |                            |   |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><u>Hypertrophy of Prostate</u>   |                            |   |  |  |  |
| 19A. DATE OF OPERATION <u>0</u>   |                            |   | 19B. MAJOR FINDINGS OF OPERATION   |  |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                            |   |  |  |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                            | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                            | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <u>March, 1950</u> to <u>June 22, 1950</u> , that I last saw the deceased alive on <u>June 22, 1950</u> , and that death occurred at <u>12:15 P.m.</u> , from the causes and on the date stated above.         |                            |   |  |  |  |
| 23A. SIGNATURE<br><u>Alvin D. Hart</u>  |                            | 23B. ADDRESS<br><u>5443 Park Heights ave</u>  |  | 23C. DATE SIGNED<br><u>6/25/50</u>                                       |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                            | 24B. DATE<br><u>June 26, 1950</u>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Mount View</u>                  |  |
| 24D. LOCATION (City, town, or county) (State)<br><u>Howard Co. Md</u>   |                            | 24E. LOCATION (City, town, or county) (State)<br><u>Md</u>  |  | 24F. LOCATION (City, town, or county) (State)<br><u>Md</u>               |  |
| 25. FUNERAL DIRECTOR<br><u>Loring Byers</u>   |                            | 25B. ADDRESS<br><u>5505 Park Heights Ave</u>  |  | 25C. ADDRESS<br><u>5505 Park Heights Ave</u>                             |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><u>JUN 26 1950</u>  |                            | REGISTRAR'S SIGNATURE<br><u>Henry J. Williams, M.D.</u>   |  | 25. FUNERAL DIRECTOR<br><u>Loring Byers</u>                              |  |
| VS 150  |                            |   |  | 93D  |  |



Dr. H. L. H. L.

5443

Ph. H. L. H. L.

324  
0 5604  
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5604  
Registered No.

|   |                       |  |  |  |  |
|---|-----------------------|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) FLORENCE KEMP MITCHELL   |                       |  | 2. DATE OF DEATH JUNE 25 1950  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland 3605 Hayward Ave  |                       |  | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE B. COUNTY<br>3605 HAYWARD AVE. |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION |                       |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>BALTIMORE 27-18                                  |  |  |
| C. Length of stay in Baltimore 3 Yrs. Mos. Days   |                       |  | D. STREET ADDRESS (If rural, give location)<br>3605 HAYWARD AVE.   |  |  |
| 5. SEX<br>F   | 6. COLOR OR RACE<br>W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>WIDOW | 8. DATE OF BIRTH<br>MARCH 18 1873  |  | 9. AGE (In years last birthday) 77     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>HOUSEWIFE        |                       | 10B. KIND OF BUSINESS OR INDUSTRY                        | 11. BIRTHPLACE (State or foreign country)<br>FREDERICK CO. VA.   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A. |
| 13. FATHER'S NAME<br>LEWIS KEMP   |                       |  | 14. MOTHER'S MAIDEN NAME<br>SARAH A. COLE  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)        |                       | 16. SOCIAL SECURITY NO.                                  | 17. INFORMANT ADDRESS<br>MISS SARAH KEMP 3605 HAYWARD AVE.   |  |  |

MEDICAL CERTIFICATION

|   |  |  |   |  |  |   |  |  |
|---|--|--|---|--|--|---|--|--|
| 18. 442X 170X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>CHRONIC congestive cardiac - renal failure |  |  | CAUSE OF DEATH<br>(A) renal failure<br>DUE TO arterio-sclerotic cardiac-vascular renal disease -<br>(B) Paget's disease of the hip<br>(C) bilateral |  |  | INTERVAL BETWEEN ONSET AND DEATH<br>about 6 mos.<br>3 years.<br>about 8 months      |  |  |
| 19A. DATE OF OPERATION 0  |  |  | 19B. MAJOR FINDINGS OF OPERATION  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |   |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |  | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK |   | 21F. HOW DID INJURY OCCUR?   |  |   |  |  |
| 22. I hereby certify that I attended the deceased from May 27, 1947 to June 25, 1950, that I last saw the deceased alive on June 25, 1950, and that death occurred at 10:30 a.m., from the causes and on the date stated above.                             |  |  |   |  |  |   |  |  |
| 23A. SIGNATURE<br>Mary J. Kemp  |  |  |   | 23B. ADDRESS<br>3030 Edmonson Ave.<br>M. D.                              |  | 23C. DATE SIGNED<br>June 25 1950  |  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   |  | 24B. DATE<br>6/28/50   |   | 24C. NAME OF CEMETERY OR CREMATORY<br>MT. PLEASANT CEM.                  |  | 24D. LOCATION (City, town, or county) (State)<br>NEWARK N. J.                       |  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br>JUN 26 1950   |  | REGISTRAR'S SIGNATURE<br>William J. Dickner  |   | 25. FUNERAL DIRECTOR<br>William J. Dickner's Sons                        |  | ADDRESS<br>50 N. ... Pa.  |  |  |



220  
50 5605  
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5605  
Registered No.

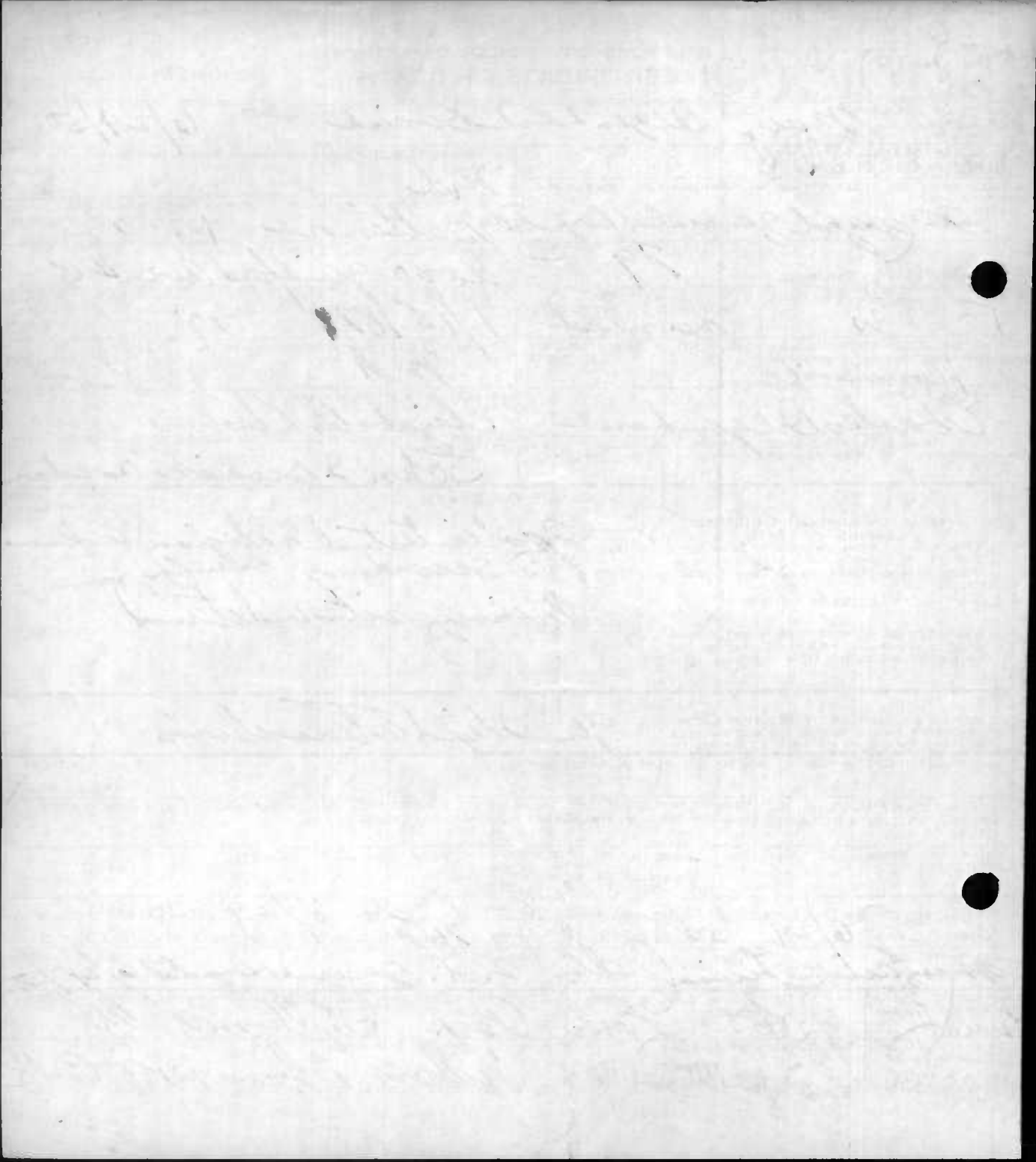
|   |                              |  |                                    |
|---|------------------------------|--|------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Mary Dezenhard Busick</i>   |                              | 2. DATE OF DEATH<br><i>6/24/50</i>   |                                    |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                              | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <i>MD</i><br>B. COUNTY |                                    |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><i>Maryd General Hospital Baltimore</i> |                              | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 12-03</i>                   |                                    |
| C. Length of stay in Baltimore<br><i>79</i> Yrs. Mos. Days  |                              | D. STREET ADDRESS (If rural, give location)<br><i>5800 Guilford Ave #18</i>  |                                    |
| 5. SEX<br><i>F</i>  | 6. COLOR OR RACE<br><i>W</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>married</i>  | 8. DATE OF BIRTH<br><i>1/15/87</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>                 |                              | 9. AGE (In years last birthday)<br><i>79</i>   |                                    |
| 10B. KIND OF BUSINESS OR INDUSTRY   |                              | 11. BIRTHPLACE (State or foreign country)<br><i>MD</i>   |                                    |
| 13. FATHER'S NAME<br><i>Charles Dezenhard</i>   |                              | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |                                    |
| 14. MOTHER'S MAIDEN NAME<br><i>Elizabeth Klemm</i>  |                              | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)                                      |                                    |
| 16. SOCIAL SECURITY NO.   |                              | 17. INFORMANT<br><i>John S. Busick as above</i>  |                                    |

|   |  |  |
|---|--|--|
| 18. <i>199.7</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br>(A) <i>Gastrointestinal malig. unknown</i><br>DUE TO<br>(B) <i>secondary</i><br>DUE TO<br>(C) <i>Primary site undetermined</i> |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>unknown</i> |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><i>Generalized arteriosclerosis</i>  |  |  |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 19A. DATE OF OPERATION<br><i>6-4-50</i>  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <i>6-4-50</i> to <i>6/24-50</i> , that I last saw the deceased alive on <i>6/24-50</i> , and that death occurred at <i>7:45</i> p.m., from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE<br><i>Maryd General Hospital</i>  |  | 23B. ADDRESS<br><i>MD. General Hospital</i>   |  | 23C. DATE SIGNED<br><i>6/24/50</i>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  |  | 24B. DATE<br><i>6/28/50</i>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>London Park Baltimore MD</i>               |  |
| 24D. LOCATION (City, town, or county) (State)  |  | 25. FUNERAL DIRECTOR<br><i>William C. ...</i>   |  | ADDRESS<br><i>1219 5th Ave</i>  |  |

UN 26 1950  
VS 150

55E



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5606  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

|  |                                  |   |  |  |  |
|--|----------------------------------|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>CYRUS SHERBAHN</b>   |                                  |   | 2. DATE OF DEATH <b>June 14, 1950</b>  |  |  |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY _____ |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>Franklin Square Hospital</b>  |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>19-02</b>                        |  |  |
| c. <b>Birth of stay in Baltimore</b>   |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>6 N. Calhoun Street</b>  |  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widower</b> | 8. DATE OF BIRTH<br><b>June 28, 1881</b>   |  | 9. AGE (In years last birthday) <b>68</b><br>If Under 1 Year: Months: Days<br>If Under 24 Hours: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Carpenter, retired</b> |                                  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Self</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Pa.</b>  |
| 13. FATHER'S NAME<br><b>Cyrus Sherbahn</b>   |                                  |   | 12. CITIZEN OF WHAT COUNTRY?<br>_____  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>    |                                  |   | 16. SOCIAL SECURITY NO. _____  |  |  |
| 17. INFORMANT<br><b>Patricia Hollands, 1524 W. Fayette St.</b>   |                                  |   | ADDRESS _____  |  |  |

|  |  |                                  |
|--|--|----------------------------------|
| 18. <b>422.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Anteriosclerotic Cardio-vascular disease</b> |  | INTERVAL BETWEEN ONSET AND DEATH |
| (A) DUE TO _____   |  |                                  |
| (B) DUE TO _____   |  |                                  |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(C) _____  |  |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>_____   |  |                                  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 19A. DATE OF OPERATION _____  |  | 19B. MAJOR FINDINGS OF OPERATION _____  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____      |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____   |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR? _____  |  |
| 22. I certify that I took charge of the remains described above, held an <u>Inspection &amp; Inquiry</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <u>natural causes</u> <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |  |   |  |   |  |
| 23A. SIGNATURE<br><i>A. J. Mc Clafferty</i>   |  | 23B. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/><br>M.D. MEDICAL INVESTIGATOR..... <input checked="" type="checkbox"/> |  | 23C. DATE SIGNED<br><b>June 15, 1950</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>6/26/50</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn</b>                               |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore County, Md.</b>   |  | 25. FUNERAL DIRECTOR<br><i>William H. Jones</i> <b>12195 Paul St.</b>   |  |   |  |
| 26. DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 26 1950</b>  |  | REGISTRAR'S SIGNATURE<br><i>William H. Jones</i>  |  |   |  |



WILLIAMS & WILKINS  
CERTIFICATE OF DEATH

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13-138962  
50 5607

## CERTIFICATE CORRECTED

6-26-50

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

50 5607

|   |                                  |   |  |  |   |
|---|----------------------------------|---|--|--|---|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Flora Gertrude Dettman</b>   |                                  |   | 2. DATE OF DEATH<br><b>6-22-50</b>   |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE<br><b>Md.</b><br>B. COUNTY |  |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>Baltimore City Hospitals</b><br><b>4940 Eastern Ave.</b>   |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b><br><b>13-02</b>             |  |   |
| C. Length of stay in Baltimore<br><b>Life</b>   |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>858 W. North Ave.</b>  |  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>   | 8. DATE OF BIRTH<br><b>Feb. 18-1902</b>  |  | 9. AGE (In years last birthday)<br><b>48-49</b>                             |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |   |
| 13. FATHER'S NAME<br><b>Frank Slicer</b> (D)  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Gertrude Chambers</b>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>Yes, no or unknown</b>  |                                  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>Baltimore City Hospitals</b><br><b>Records: 4940 Eastern Ave.</b>  |   |
| 18. <b>760 X</b> <b>E 9547</b> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Abscess of Right Leg</b><br>DUE TO<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Diabetes Mellitus</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                                  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| 19A. DATE OF OPERATION<br><b>June 18-1950</b>   |                                  |   |  |  | 19B. MAJOR FINDINGS OF OPERATION<br><b>Incision and drainage of abscess</b> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br><input checked="" type="checkbox"/>  |                                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Hospital</b>       |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>Baltimore City Hospital</b><br><b>4940 Eastern Ave.</b> |   |
| 21D. TIME (Month) (Day) (Year) (Hour)<br><b>June 22, 1950 5:50 P.m.</b>   |                                  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?<br><b>Injection of sodium pentothal anesthetic</b>  |   |
| 22. I hereby certify that I attended the deceased from <b>6-16-</b> <b>1950</b> , to <b>6-22-</b> <b>1950</b> , that I last saw the deceased alive on <b>6-22-</b> <b>1950</b> , and that death occurred at <b>5:52 P.M.</b> m., from the causes and on the date stated above.  |                                  |   |  |  |   |
| 23A. SIGNATURE<br><b>Ch. C. Rogers</b> M. D.  |                                  |   | 23B. ADDRESS<br><b>4940 Eastern Ave.</b>   |  | 23C. DATE SIGNED<br><b>6-23-50</b>  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 24B. DATE<br><b>6/26/50</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet</b>  |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Balto Md</b>  |                                  | 25. FUNERAL DIRECTOR<br><b>Wm. C. Inc. 1217 St. Paul St.</b>  |  |  |   |

VS 150

TO BE APPROVED BY THE MEDICAL EXAMINER

61

"Dr Fisher linked absence to diabetes  
by phone — 6.27.50 ES

550

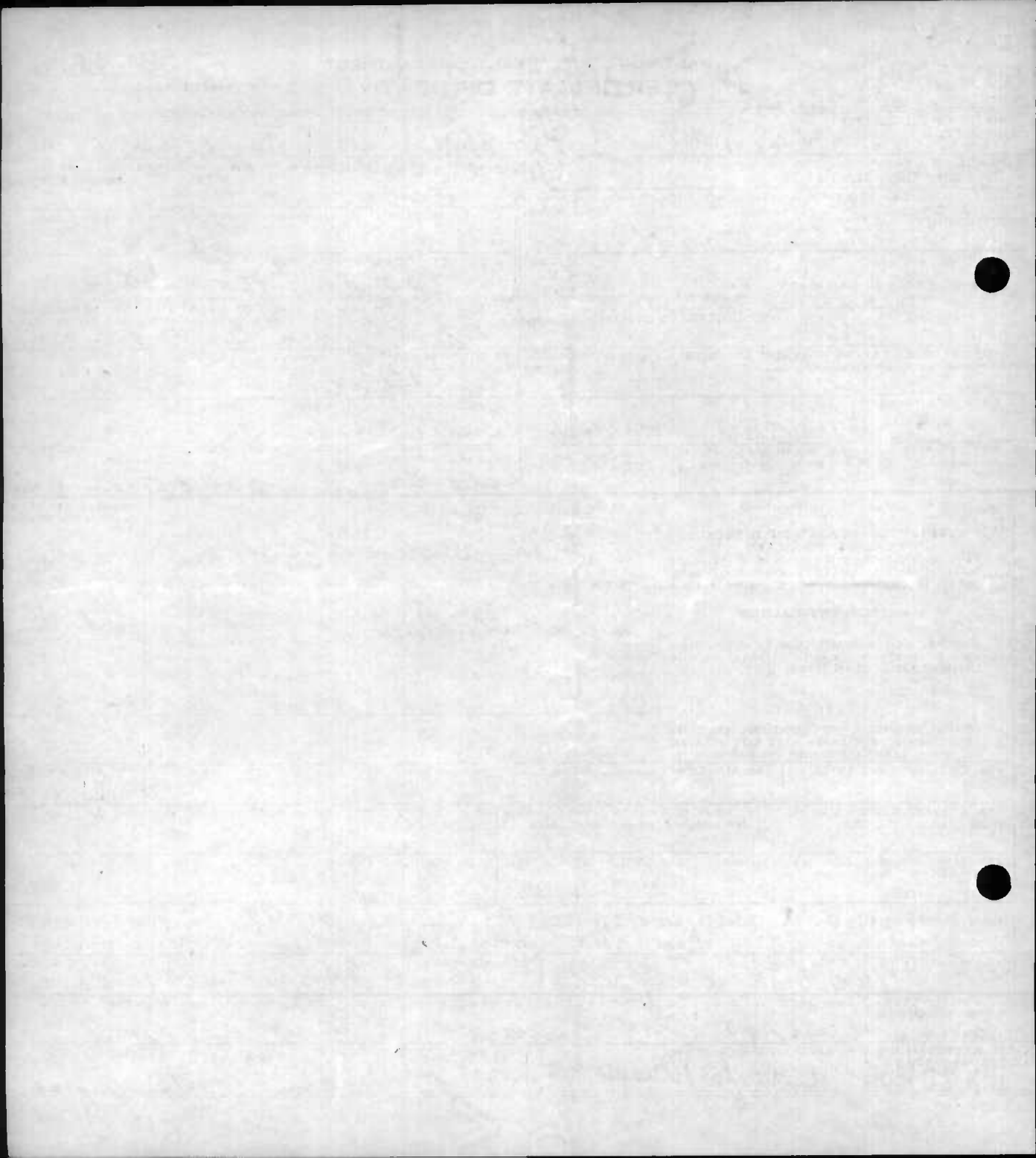
50 5608

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5608

|   |                    |  |  |  |                                   |
|---|--------------------|--|--|--|-----------------------------------|
| BIRTH NO. 50-030615   |                    | 1. NAME OF DECEASED<br>(Type or Print) WILLARD SHANNON, JR.  |  | 2. DATE OF DEATH 6/24/50   |                                   |
| 3. PLACE OF DEATH:<br>a. Baltimore City, Maryland   |                    | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>a. STATE Balt., Md. b. COUNTY |  |  |                                   |
| b. FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY H.   |                    | c. CITY OR TOWN 21-01  |  |  |                                   |
| c. Length of stay in Baltimore 4- Yrs. Mos. Days  |                    | d. STREET ADDRESS (If rural, give location) 230 S. Fremont Ave   |  |  |                                   |
| 5. SEX M  | 6. COLOR OR RACE B | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  |  | 8. DATE OF BIRTH Feb. 1950   | 9. AGE (In years last birthday) 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                    | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country) Balt.                          | 12. CITIZEN OF WHAT COUNTRY       |
| 13. FATHER'S NAME WILLARD SHANNON   |                    | 14. MOTHER'S MAIDEN NAME Katie Barnes  |  |  |                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no  |                    | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS Katie Shannon - 230 S. Fremont Ave                 |                                   |
| 18. 571.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                   |                    | (A) Dehydration + acidosis   |  | INTERVAL BETWEEN ONSET AND DEATH 7 days                                  |                                   |
| DUE TO  |                    | (B) diarrhea   |  | 21 days  |                                   |
| DUE TO  |                    | (C)  |  |  |                                   |
| 19a. DATE OF OPERATION 0  |                    |  |  |  |                                   |
| 19b. MAJOR FINDINGS OF OPERATION  |                    |  |  |  |                                   |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                    |  |  |  |                                   |
| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                    | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                               |  | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                   |
| 21d. TIME (Month) (Day) (Year) (Hour) INJURY  |                    | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                 |  | 21f. HOW DID INJURY OCCUR?   |                                   |
| 22. I hereby certify that I attended the deceased from 6/17, 1950, to 6/24, 1950, that I last saw the deceased alive on 6/24, 1950, and that death occurred at 12:30 pm., from the causes and on the date stated above. |                    |  |  |  |                                   |
| 23a. SIGNATURE Herbert K. Spence, M.D.  |                    | 23b. ADDRESS Univ. Hosp. Balt.   |  | 23c. DATE SIGNED 6/24/50   |                                   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial  |                    | 24b. DATE 6/24/50  |  | 24c. NAME OF CEMETERY OR CREMATORY Mt. Calvary                           |                                   |
| 24d. LOCATION (City, town, or county) A. A. Co., Md.  |                    | 24e. LOCATION (State) A. A. Co., Md.   |  |  |                                   |
| DATE RECEIVED BY LOCAL REGISTRAR JUN 26 1950  |                    | REGISTRAR'S SIGNATURE Huntington Williams, M.D.  |  | 25. FUNERAL DIRECTOR J. L. Brown & Son - Montgomery Co.                  |                                   |

MEDICAL CERTIFICATION



0-645  
50 5609

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5609  
Registered No.

BIRTH NO. 50-12271

|   |                              |  |   |  |   |
|---|------------------------------|--|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>BABY BOY DARLING ("A" Twin)</b>   |                              |  | 2. DATE OF DEATH<br><b>6-21-50</b>  |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland ✓   |                              |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD.</b><br>B. COUNTY |  |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION<br><b>WOMANS HOSPITAL</b> |                              |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTO 27-38</b>                        |  |   |
| C. Length of stay in Baltimore <b>12 HRS.</b>   |                              |  | D. STREET ADDRESS (If rural, give location)<br><b>1303 Ramblewood Road</b>  |  |   |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>S.</b> | 8. DATE OF BIRTH<br><b>6-21-50</b>  |  | 9. AGE (In years last birthday)<br><b>—</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>—</b>                                   |                              | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>                | 11. BIRTHPLACE (State or foreign country)<br><b>BALTO</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b> |
| 13. FATHER'S NAME<br><b>PHILIP V. DARLING</b>   |                              |  | 14. MOTHER'S MAIDEN NAME<br><b>ILSE MUELLER.</b>  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>—</b>   |                              | 16. SOCIAL SECURITY NO.<br><b>—</b>                          | 17. INFORMANT<br><b>MOTHER</b>  |  |   |
|   |                              |  | ADDRESS<br><b>1303 RAMBLEWOOD RD</b>  |  |   |

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| 18. <b>761.5</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | CAUSE OF DEATH  |  | INTERVAL BETWEEN ONSET AND DEATH<br><br><b>12 HRS.</b> |
|  | (A) <b>PREMATURITY</b><br>DUE TO <b>PREMATURE SEPARATION OF PLACENTA.</b> |  |  |
|  | (B)<br>DUE TO   |  |  |
| (C)<br>DUE TO  |   |  |  |

|  |   |  |
|--|---|--|
| 19A. DATE OF OPERATION<br><b>6-21-50</b>   | 19B. MAJOR FINDINGS OF OPERATION<br><b>Premature Separation of placenta</b>                               | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)<br><b>—</b>   | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br><b>—</b>     | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>—</b> |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>INJURY<br><b>—</b>  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?<br><b>—</b>   |
| 22. I hereby certify that I attended the deceased from <b>6-21</b> 19 <b>50</b> , to <b>6-21</b> 19 <b>50</b> , that I last saw the deceased alive on <b>6-21</b> 19 <b>50</b> , and that death occurred at <b>7</b> m., from the causes and on the date stated above. |   |  |
| 23A. SIGNATURE<br><b>Hermon C. Kelly</b>   | 23B. ADDRESS<br>M. D. <b>13 E. Eager St</b>   | 23C. DATE SIGNED<br><b>6-23-50</b>   |

|  |                                 |  |   |
|--|---------------------------------|--|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>REMOVAL.</b> | 24B. DATE<br><b>JUN 26 1950</b> | 24C. NAME OF CEMETERY OR CREMATORY<br><b>JOHN HOPKINS MEDICAL SCHOOL</b> | 24D. LOCATION (City, town, or county) (State)<br><b>JUN 23 1950</b> |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 26 1950</b>       |                                 | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b>                | 25. FUNERAL DIRECTOR<br><b>Commissioner of Health</b>               |

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

CAS. (Rev. 1-1-60)

8-1-60

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1000 H. H. H.

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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5610  
Registered No. \_\_\_\_\_

BIRTH NO. 50-12272

|  |                              |  |   |  |   |
|--|------------------------------|--|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Baby <del>Girl</del> DARLING "B" Twin</b>  |                              |  | 2. DATE OF DEATH<br><b>6-21-50</b>  |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland ✓  |                              |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD.</b><br>B. COUNTY _____ |  |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTE <b>WOMAN'S HOSPITAL.</b> |                              |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTO 27-38</b>                              |  |   |
| c. Length of stay in Baltimore <b>12 HRS</b><br>Yrs. _____<br>Mos. _____<br>Days _____   |                              |  | O. STREET ADDRESS (If rural, give location)<br><b>1303 Ramblerwood Road</b>   |  |   |
| 5. SEX<br><b>Em</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>S.</b> | 8. DATE OF BIRTH<br><b>6-21-50</b>  | 9. AGE (In years last birthday)<br>_____ | 10. Under 1 Year<br>Months: _____ Days: _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>_____                                   |                              |  | 10B. KIND OF BUSINESS OR INDUSTRY<br>_____  |  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>BALTO - MD.</b>  |                              |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |   |
| 13. FATHER'S NAME<br><b>PHILIP V. DARLING</b>  |                              |  | 14. MOTHER'S MAIDEN NAME<br><b>ILSE MUELLER.</b>  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>No</b>   |                              |  | 16. SOCIAL SECURITY NO.<br>_____  |  |   |
| 17. INFORMANT<br><b>MOTHER</b>   |                              |  | ADDRESS<br><b>1303 RAMBLEWOOD RD.</b>   |  |   |

|  |   |
|--|---|
| 18. <b>761.5</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br><b>PREMATURITY</b><br><b>PREMATURE SEPARATION OF PLACENTA.</b><br>DUE TO _____<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | CAUSE OF DEATH<br><br>INTERVAL BETWEEN ONSET AND DEATH<br><br><b>12 HRS</b> |
|--|---|

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|--|---|---|
| 19A. DATE OF OPERATION<br><b>6-21-50</b>   | 19B. MAJOR FINDINGS OF OPERATION<br><b>PREMATURE SEPARATION OF PLACENTA</b>                               | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)<br>_____  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br>_____        | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>_____   |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>INJURY _____  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?<br>_____   |
| 22. I hereby certify that I attended the deceased from <b>6-21-1950</b> to <b>6-21-1950</b> , that I last saw the deceased alive on <b>6-21-50</b> , 19____, and that death occurred at <b>2:30 p m.</b> , from the causes and on the date stated above. |   |   |
| 23A. SIGNATURE<br><b>Theron C. Kelly</b>   | 23B. ADDRESS<br>M. O. <b>136 E. Eager St</b>  | 23C. DATE SIGNED<br><b>6-23-50</b>  |

|  |   |  |   |
|--|---|--|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>_____     | 24B. DATE<br>_____  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>JOHN HOPKINS MEDICAL SCHOOL</b> | 24D. LOCATION (City, town, or county) (State)<br><b>JUN 23 1950</b> |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 26 1950</b> | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b> | 25. FUNERAL DIRECTOR<br><b>W. C. H. S.</b>                               | ADDRESS<br>_____  |

CERTIFICATE OF DEATH

8-21-20

Mr

John

1

John

1222 Hudson

Mother

DECLARATION OF DEATH  
BY MEDICAL PERSONNEL

DECLARATION OF DEATH

DECLARATION OF DEATH  
BY MEDICAL PERSONNEL

350  
5611

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5611

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ARTHUR W. BODIN

2. DATE  
OF  
DEATH

JUNE 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

SOUTH BALTIMORE GEN'L HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

ANNE ARUNDEL

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

GLEN BURNIE

(RURAL)

D. STREET ADDRESS (If rural, give location)

1819 LANSING ROAD.

5200

C. Length of stay in Baltimore

3

Days

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

Nov. 25, 1885

9. AGE (In years last birthday)

64

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

ACCOUNTING

10B. KIND OF BUSINESS OR INDUSTRY

AUDITING, U.S.G.

11. BIRTHPLACE (State or foreign country)

WOODLAWN

ME.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

OTTO BODIN

14. MOTHER'S MAIDEN NAME

JOSEPHINE (UNKNOWN)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

MR ROSE M. BODIN.

ADDRESS

1819 LANSING RD  
GLEN BURNIE, MD.

18.

331X,

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL HEMORRHAGE

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) GENERALIZED ARTERIO SCLEROSIS

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/20 1950, to 6/23 1950, that I last saw the deceased alive on 6/23 1950, and that death occurred at 11:20 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Samuel P. Scalia

M. D.

23B. ADDRESS

1213 Light Street

23C. DATE SIGNED

6/23/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

CREMATION

JUNE 26, 1950

LOLTON PARK

BALTIMORE

MD.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

Thomas W. Singleton

ADDRESS

Glen Burnie, Md.

CONTRACT OF SALE

THIS CONTRACT OF SALE is made this 1st day of May 1900

between the undersigned

of the County of ... State of ...

and the undersigned

of the County of ... State of ...

for and to the effect that the undersigned

do hereby agree to sell and convey unto the undersigned

all that certain ...

containing ...

more or less ...

together with all the rights and appurtenances thereto in anywise by law in anywise in anywise

in anywise by law in anywise in anywise

in anywise by law in anywise in anywise

in anywise by law in anywise in anywise

in anywise by law in anywise in anywise

in anywise by law in anywise in anywise

in anywise by law in anywise in anywise

in anywise by law in anywise in anywise

512  
5612

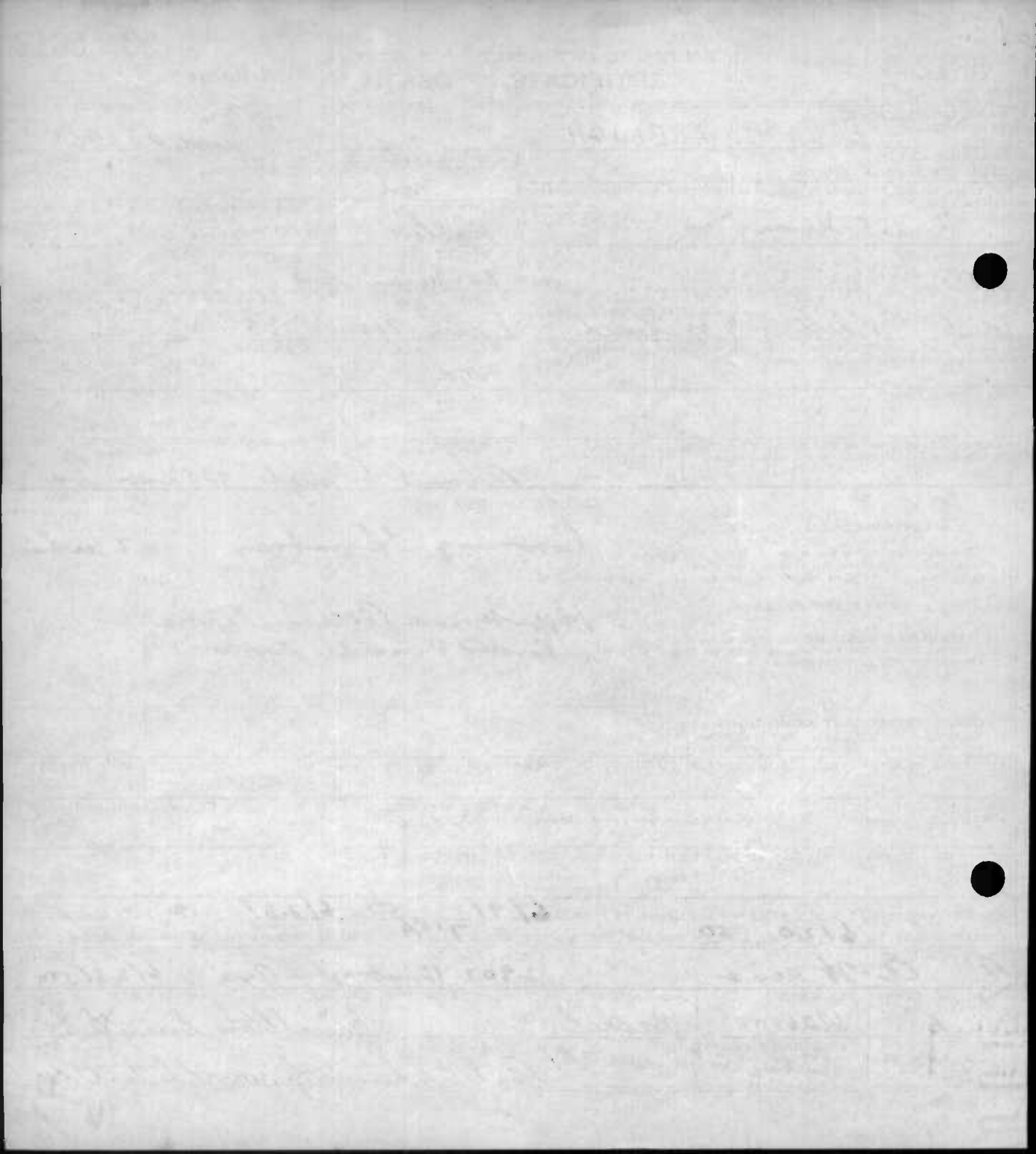
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5612

Registered No. \_\_\_\_\_

|   |   |  |   |  |   |
|---|---|--|---|--|---|
| BIRTH NO. _____   |   | 1. NAME OF DECEASED<br>(Type or Print) <b>ELLA J. ARBAUGH.</b>   |   | 2. DATE OF DEATH<br><b>June 23 1960</b>                                  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |   | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY _____ |   |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>825 Union Ave.</b>  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Balto.</b> <b>13-07</b>                   |   |  |   |
| C. Length of stay in Baltimore<br>Yrs. _____ Mos. _____ Days _____  |   | D. STREET ADDRESS (If rural, give location)<br><b>825 Union Ave.</b>   |   |  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)<br><b>Widowed</b>   | 8. DATE OF BIRTH<br><b>Sept 5, 1866</b>   | 9. AGE (in years last birthday)<br><b>83</b>                             | 10. Under 1 Year Months: _____ Days: _____ 11. Under 24 Hours Hours: _____ Min: _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>_____  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br>_____   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>                  |   |
| 12. CITIZEN OF WHAT COUNTRY?<br>_____   |   | 13. FATHER'S NAME<br><b>?</b>  |   |  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>?</b>  |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br>Yes, no or unknown) _____             |   |  |   |
| 16. SOCIAL SECURITY NO.<br>_____  |   | 17. INFORMANT ADDRESS<br><b>Vernon L. Arbaugh 825 Union Ave.</b>   |   |  |   |
| 18. <b>420.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Coronary Thrombosis</b>     |   | CAUSE OF DEATH   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 when</b>                        |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Hypertensive Atherosclerotic Cardio Vascular Disease</b>   |   | (A) DUE TO   |   | (B) DUE TO   |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>II</b>  |   | (C) DUE TO   |   |  |   |
| 19A. DATE OF OPERATION<br><b>6/20/50</b>  |   | 19B. MAJOR FINDINGS OF OPERATION   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |   |  |   |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |  |   |
| 22. I hereby certify that I attended the deceased from <b>6/9/1950</b> , to <b>6/23/1950</b> , that I last saw the deceased alive on <b>6/20, 1950</b> , and that death occurred at <b>7:15 A. m.</b> , from the causes and on the date stated above. |   |  |   |  |   |
| 23A. SIGNATURE<br><b>A. Weiss</b>   |   | 23B. ADDRESS<br>M. D. <b>2902 Huntington Ave</b>   |   | 23C. DATE SIGNED<br><b>6/23/50</b>                                       |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 24B. DATE<br><b>6/26/50</b>   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Bethel</b>  | 24D. LOCATION (City, town, or county) (State)<br><b>Barrollton, Barroll Co.</b> |  |   |
| DATE RECEIVED BY<br><b>JUN 26 1960</b>  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b>   | 25. FUNERAL DIRECTOR ADDRESS<br><b>Paul C. Chenoweth, 3615 N. Chestnut Ave.</b>  |   |  |   |





32  
50 5613BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5613

BIRTH NO.

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Catherine Custis</b>  |  |  | 2. DATE OF DEATH<br><b>June 24, 1950</b>  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>2101 W. Cold Spring</b>                          |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Bellevue, Md</b> B. COUNTY <b>Albany</b> |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Bar-Wil- Ba Con. Home</b>                               |  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore, Maryland</b>                                    |  |  |
| D. STREET ADDRESS (If rural, give location)<br><b>2101 W. Cold Spring Lane</b>                        |  |  | E. ZIP CODE<br><b>7000</b>  |  |  |
| 5. SEX<br><b>Female</b>   |  |  | 6. COLOR OR RACE<br><b>Colored</b>  |  |  |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b>                                     |  |  | 8. DATE OF BIRTH<br><b>Unknown</b>  |  |  |
| 9. AGE (In years last birthday)<br><b>73</b>  |  |  | 10. UNDER 1 Year Months: Days<br><b>73</b>  |  |  |
| 11. UNDER 24 Hours Hours: Min.<br><b>73</b>   |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>Crisfield, Maryland</b>  |  |  |
| 13. FATHER'S NAME<br><b>Unknown</b>   |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>Unknown</b> |  |  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   |  |  |
| 17. INFORMANT<br><b>Mrs. Sarah Turner</b>   |  |  | ADDRESS<br><b>Crisfield, Md.</b>  |  |  |

|   |  |   |                                  |
|---|--|---|----------------------------------|
| 18. <b>442X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cardio-Vascular Renal Disease</b><br>DUE TO<br><b>Arterio- Sclerotic Gangrene of left Foot</b><br>DUE TO<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  | CAUSE OF DEATH<br><b>Cardio-Vascular Renal Disease</b><br><b>Arterio- Sclerotic Gangrene of left Foot</b> | INTERVAL BETWEEN ONSET AND DEATH |
|---|--|---|----------------------------------|

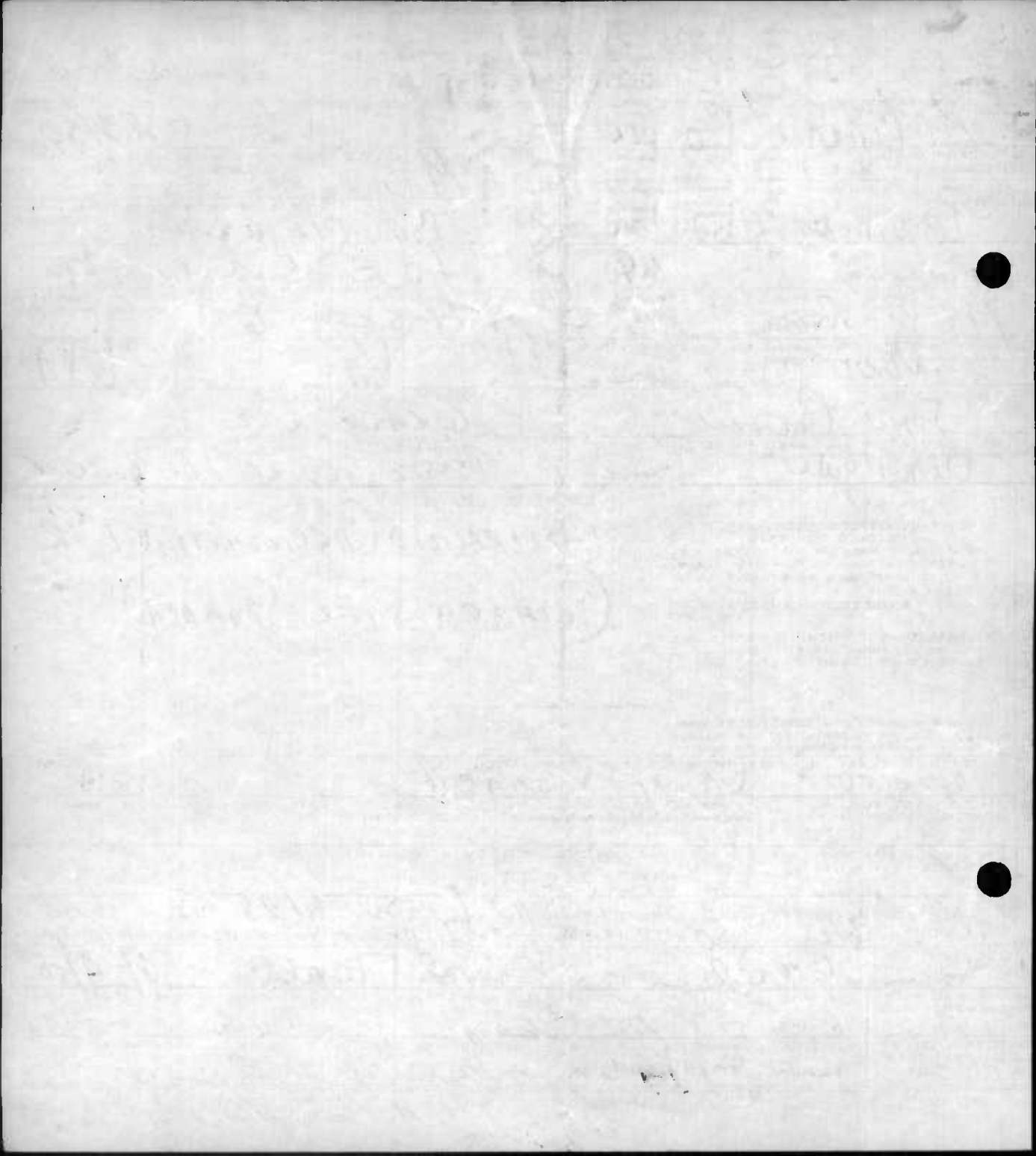
|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 19A. DATE OF OPERATION<br><b>6/24/50</b>   |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                             |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)<br><b>B.</b>  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br><b>1011 N. Arlington Ave</b> |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)<br><b>Baltimore City</b> |  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br><b>6/24/50 4-8-50</b>   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                 |  | 21F. HOW DID INJURY OCCUR?<br><b>6/24-50</b>   |  |
| 22. I hereby certify that I attended the deceased from <b>6/24/50</b> , to <b>6/24-50</b> , 19__, that I last saw the deceased alive on <b>6/24/50</b> , 19__, and that death occurred at <b>5/15 p.m.</b> , 19__, from the causes and on the date stated above. |  |   |  |  |  |

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 23A. SIGNATURE<br><b>R. D. Jackson</b>                                 |  | 23B. ADDRESS<br><b>1011 N. Arlington Ave</b>        |  | 23C. DATE SIGNED<br><b>6/24/50</b>                     |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>B.</b>                 |  | 24B. DATE<br><b>6-28-50</b>                         |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>W. Auburn</b> |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore City</b> |  | 24E. FUNERAL DIRECTOR<br><b>Samuel W. Sullivan</b>  |  | ADDRESS<br><b>1011 N. Arlington Ave 131a</b>           |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 26 1950</b>                 |  | REGISTRAR'S SIGNATURE<br><b>William W. Williams</b> |  | 52046  |  |

CERTIFICATE OF DEATH

|                             |  |                               |  |
|-----------------------------|--|-------------------------------|--|
| Name of Deceased            |  | Date of Birth                 |  |
| Sex                         |  | Race                          |  |
| Usual Residence             |  | Place of Birth                |  |
| Cause of Death              |  | Date of Death                 |  |
| Place of Death              |  | Signature of Physician        |  |
| Signature of Registrar      |  | Signature of Coroner          |  |
| Date of Registration        |  | Signature of Medical Examiner |  |
| Signature of Burial Officer |  | Signature of Undertaker       |  |
| Signature of Cemetery       |  | Signature of Funeral Home     |  |
| Signature of Family         |  | Signature of Friends          |  |
| Signature of Church         |  | Signature of Community        |  |
| Signature of State          |  | Signature of Nation           |  |

| BIRTH NO.   |                           | BALTIMORE CITY HEALTH DEPARTMENT   |                             | Registered No.   |  |
|---|---------------------------|--|-----------------------------|--|--|
| 50 5614   |                           | CLIFFORD CLIFTON COLVIN  |                             | 50 5614  |  |
| 1. NAME OF DECEASED<br>(Type or Print)  |                           | CLIFFORD CLIFTON COLVIN  |                             | 2. DATE OF DEATH<br>6/23/50  |  |
| 3. PLACE OF DEATH:<br>a. Baltimore City, Maryland   |                           | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE MD B. COUNTY |                             | C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)<br>BALTIMORE |  |
| b. FULL NAME OF HOSPITAL OR INSTITUTION<br>PROVIDENT HOSPITAL   |                           | d. STREET ADDRESS (If rural, give location)<br>102 BURCINE ST  |                             | e. LENGTH OF STAY IN BALTIMORE<br>64 Yrs. Mos. Days  |  |
| 5. SEX<br>M   | 6. COLOR OF RACE<br>NEGRO | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>M   | 8. DATE OF BIRTH<br>8-29-82 | 9. AGE (In years, last birthday)<br>67   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>NONE   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>Genl. Laborer   |                             | 11. BIRTHPLACE (State or foreign country)<br>VA  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br>USA   |                           | 13. FATHER'S NAME<br>JOHN COLVIN   |                             | 14. MOTHER'S MAIDEN NAME<br>GRACE CEE  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br>UNKNOWN  |                           | 16. SOCIAL SECURITY NO.<br>none  |                             | 17. INFORMANT<br>BESSIE COLVIN 102 BURCINE   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>DISEASE OR CONDITION<br>151X<br>GENERALIZED CARCINOMATOSIS<br>(PRIMARY SITE STOMACH) |                           | CAUSE OF DEATH<br>(A) DUE TO<br>(B) DUE TO<br>(C)  |                             | INTERVAL BETWEEN ONSET AND DEATH<br>1 YR   |  |
| 19. DATE OF OPERATION<br>10/20/50   |                           | 19b. MAJOR FINDINGS OF OPERATION<br>CA OF STOMACH  |                             | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>        |  |
| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                           | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                      |                             | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                   |  |
| 21d. TIME (Month) (Day) (Year) (Hour)<br>INJURY   |                           | 21e. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>      |                             | 21f. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from 5/17/1950 to 6/23/1950, that I last saw the deceased alive on 6/23/1950, and that death occurred at 7:15 p.m., from the causes and on the date stated above.   |                           |  |                             |  |  |
| 23a. SIGNATURE<br>Samuel W. Sullivan  |                           | 23b. ADDRESS<br>Baltimore Hospital   |                             | 23c. DATE SIGNED<br>6/24/50  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br>B.   |                           | 24b. DATE<br>6-27-50   |                             | 24c. NAME OF CEMETERY OR CREMATORY<br>Mt. Calvary  |  |
| 24d. LOCATION (City, town, or county) (State)<br>A. A. Co. Md   |                           | 24e. DATE RECEIVED BY LOCAL REGISTRAR<br>N 26 1950   |                             | 24f. REGISTRAR'S SIGNATURE<br>Huntington Williams, M.D.                                    |  |
| 24g. GENERAL DIRECTOR<br>Samuel W. Sullivan, Jr.  |                           | 24h. ADDRESS<br>98899 1011 N. Huntington Ave 46B   |                             |  |  |



300  
50 5615CRESTON WOOD  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5615

|  |                           |   |                                  |
|--|---------------------------|---|----------------------------------|
| BIRTH NO.  |                           | 2. DATE OF DEATH June 23, 1950  |                                  |
| 1. NAME OF DECEASED (Type or Print) CRESTON  |                           | WOOD SR   |                                  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                           | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland<br>B. COUNTY                                     |                                  |
| 5. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION Baltimore City Hospital  |                           | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 26-11   |                                  |
| 6. Date of stay in Baltimore<br>Yrs. Mos. Days   |                           | D. STREET ADDRESS (If rural, give location)<br>922 S. Clinton Street  |                                  |
| 5. SEX<br>Male   | 6. COLOR OR RACE<br>White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Married  | 8. DATE OF BIRTH<br>Mar. 12-1902 |
| 9. AGE (In years last birthday)<br>48  |                           | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Hard BOUNDER - COAL MINING                                    |                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Hard BOUNDER - COAL MINING  |                           | 10b. KIND OF BUSINESS OR INDUSTRY   |                                  |
| 11. BIRTHPLACE (State or foreign country)<br>Md  |                           | 12. CITIZEN OF WHAT COUNTRY?  |                                  |
| 13. FATHER'S NAME<br>Mark  |                           | 14. MOTHER'S MAIDEN NAME<br>Sarah Carbrish  |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br>Unknown   |                           | 16. SOCIAL SECURITY NO.   |                                  |
| 17. INFORMANT<br>Kate Wardell 916 S Clinton St   |                           | ADDRESS   |                                  |
| 18. 420.1<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br>Crowning Pulmonary Disease<br>DUE TO<br>(A) ...<br>(B) ...<br>(C) ...<br>INTERVAL BETWEEN ONSET AND DEATH  |                           |   |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                           |   |                                  |
| 19a. DATE OF OPERATION   |                           | 19b. MAJOR FINDINGS OF OPERATION  |                                  |
| 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                           |   |                                  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                           | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |                                  |
| 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                           | 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                  |
| 21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                           | 21f. HOW DID INJURY OCCUR?  |                                  |
| 22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |                           |   |                                  |
| 23a. SIGNATURE<br>E. J. Williams   |                           | 23b. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/> M.D. |                                  |
| 23c. DATE SIGNED<br>6-23-50  |                           |   |                                  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |                           | 24b. DATE<br>6/26/50  |                                  |
| 24c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn   |                           | 24d. LOCATION (City, town, or county) (State)<br>Baltimore  |                                  |
| DATE RECEIVED BY LOCAL REGISTRAR<br>N 26 1950  |                           | REGISTRAR'S SIGNATURE<br>Huntington Williams, M.D.  |                                  |
| 25. FUNERAL DIRECTOR<br>454 V2   |                           | ADDRESS<br>Clarice Hoffmann 1639 Broadway<br>94a  |                                  |





520  
0 5616BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5616

|  |                           |  |                                    |   |   |
|--|---------------------------|--|------------------------------------|---|---|
| BIRTH NO.  |                           | 1. NAME OF DECEASED<br>(Type or Print) MARY CATHERINE LEHNEIS  |                                    | 2. DATE OF DEATH<br>June 23, 1950   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland 518 N. Streeper St.  |                           | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Md.<br>B. COUNTY |                                    |   |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION  |                           | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 7-01                     |                                    |   |   |
| C. Length of stay in Baltimore 67 years  |                           | D. STREET ADDRESS (If rural, give location)<br>518 N. Streeper St.   |                                    |   |   |
| 5. SEX<br>female   | 6. COLOR OR RACE<br>white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>married   | 8. DATE OF BIRTH<br>March 29, 1881 | 9. AGE (In years last birthday)<br>69   | 10. Under 1 Year<br>Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>housewife   |                           | 10B. KIND OF BUSINESS OR INDUSTRY<br>at home   |                                    | 11. BIRTHPLACE (State or foreign country)<br>Germany                                |   |
| 13. FATHER'S NAME<br>Adam Borgmann   |                           | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.   |                                    |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)  |                           | 16. SOCIAL SECURITY NO.  |                                    | 14. MOTHER'S MAIDEN NAME<br>unknown   |   |
| 17. INFORMANT<br>Mrs. Mildred Grubert, dght.   |                           | ADDRESS<br>3005 Arizona Ave.   |                                    |   |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>592x I<br>Chronic glaucoma - 6-4-1945 |                           | CAUSE OF DEATH<br>(A) DUE TO<br>(B) DUE TO<br>(C) DUE TO<br>Hypertension - Cardio-Vascular Disease                 |                                    | INTERVAL BETWEEN ONSET AND DEATH<br>5 yrs.  |   |
| 19A. DATE OF OPERATION<br>0  |                           | 19B. MAJOR FINDINGS OF OPERATION   |                                    | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |                           | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                          |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |   |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>INJURY  |                           | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>          |                                    | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I hereby certify that I attended the deceased from 6-10-1950, to 6-23-1950, that I last saw the deceased alive on 6-23-1950, and that death occurred at 8:30 p. m., from the causes and on the date stated above.                        |                           |  |                                    |   |   |
| 23A. SIGNATURE<br>[Signature]  |                           | 23B. ADDRESS<br>2201 E. Howard St.<br>M. D.  |                                    | 23C. DATE SIGNED<br>6-24-50   |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |                           | 24B. DATE<br>June 26, 1950   |                                    | 24C. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery                             |   |
| 24D. LOCATION (City, town, or county)<br>Taylor Ave., Baltimore, Md.   |                           | 24E. LOCATION (State)<br>Md.   |                                    |   |   |
| DATE RECEIVED BY LOCAL REGISTRAR<br>JUN 26 1950  |                           | REGISTRAR'S SIGNATURE<br>[Signature]   |                                    | 25. FUNERAL DIRECTOR<br>Schimunek Funeral Home, Inc.<br>2801 45-5 E. Madison St.    |   |

DECLARATION OF DEATH

STATE OF NEW YORK

County of \_\_\_\_\_

City of \_\_\_\_\_

I, \_\_\_\_\_

do hereby certify that \_\_\_\_\_

has died at \_\_\_\_\_

on the \_\_\_\_\_ day of \_\_\_\_\_

at the age of \_\_\_\_\_ years

and that the death was caused by \_\_\_\_\_

and that the death was not the result of \_\_\_\_\_

and that the death was not the result of \_\_\_\_\_

and that the death was not the result of \_\_\_\_\_

and that the death was not the result of \_\_\_\_\_

and that the death was not the result of \_\_\_\_\_

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and that the death was not the result of \_\_\_\_\_

and that the death was not the result of \_\_\_\_\_

and that the death was not the result of \_\_\_\_\_

363  
5617BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5617

|   |                           |   |                                       |
|---|---------------------------|---|---------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) ESTILL   |                           | 2. DATE OF DEATH June 24, 1950  |                                       |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                           | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland  |                                       |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>Franklin Square Hospital  |                           | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore   |                                       |
| C. Length of stay in Baltimore<br>Yrs. Mos. Days  |                           | D. STREET ADDRESS (If rural, give location)<br>109 N. Carey Street  |                                       |
| 5. SEX<br>Male  | 6. COLOR OR RACE<br>White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Married  | 8. DATE OF BIRTH<br>6-26-06           |
| 9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Meat Cutter   |                           | 9B. KIND OF BUSINESS OR INDUSTRY<br>Retired   | 9. AGE (In years last birthday)<br>43 |
| 10. FATHER'S NAME<br>John Stroud  |                           | 11. BIRTHPLACE (State or foreign country)<br>Alamo, Georgia   |                                       |
| 12. MOTHER'S MAIDEN NAME<br>Ethel Elder   |                           | 13. CITIZEN OF WHAT COUNTRY?  |                                       |
| 14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)<br>no  |                           | 15. SOCIAL SECURITY NO.   |                                       |
| 16. ADDRESS<br>Russell Stroud 616 Collins Avenue  |                           | 17. ADDRESS   |                                       |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>DUE TO (A) Bronchopneumonia<br>ANTECEDENT CAUSES<br>DUE TO (B)<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO (C)<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>Chronic alcoholism<br>INTERVAL BETWEEN ONSET AND DEATH<br>1 day |                           |   |                                       |
| 19A. DATE OF OPERATION  |                           | 19B. MAJOR FINDINGS OF OPERATION  |                                       |
| 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                           |   |                                       |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                       |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                           | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                       |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                           | 21F. HOW DID INJURY OCCUR?  |                                       |
| 22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .  |                           |   |                                       |
| 23A. SIGNATURE<br>B. S. Fisher  |                           | 23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/> |                                       |
| 23C. DATE SIGNED<br>6-25-50   |                           | 23D. NAME OF CEMETERY OR CREMATORY<br>ALAMO CEMETERY  |                                       |
| 23E. LOCATION (City, town, or county)<br>ALAMO GEORGIA  |                           | 23F. DATE RECEIVED BY LOCAL REGISTRAR<br>JUN 26 1950  |                                       |
| 23G. REGISTRAR'S SIGNATURE<br>Huntington Williams, M.D.   |                           | 23H. FUNERAL DIRECTOR<br>W. A. Walters  |                                       |
| 23I. V S 151  |                           | 23J. 45261  |                                       |



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5618

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5618

Registered No. \_\_\_\_\_

BIRTH NO. 50-08835

1. NAME OF DECEASED  
(Type or Print)

Charles C. Caldwell

2. DATE  
OF  
DEATH

June 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

1822 Madison Ave.

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

May 1, 1950

9. AGE (in years  
last birthday)If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.

1 23

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Charles Caldwell

14. MOTHER'S MAIDEN NAME

Bessie Hatwood

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Bessie Caldwell 1822 Madison

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) .....  
DUE TO

Bronchopneumonia

1 week

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) .....  
DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) .....

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/23, 1950, to 6/24, 1950, that I last saw the  
deceased alive on 6/24, 1950, and that death occurred at 7 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

6-26-50

24C. NAME OF CEMETERY OR CREMATORY

Western Star Cem

24D. LOCATION (City, town, or county)

Baltimore Co., Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

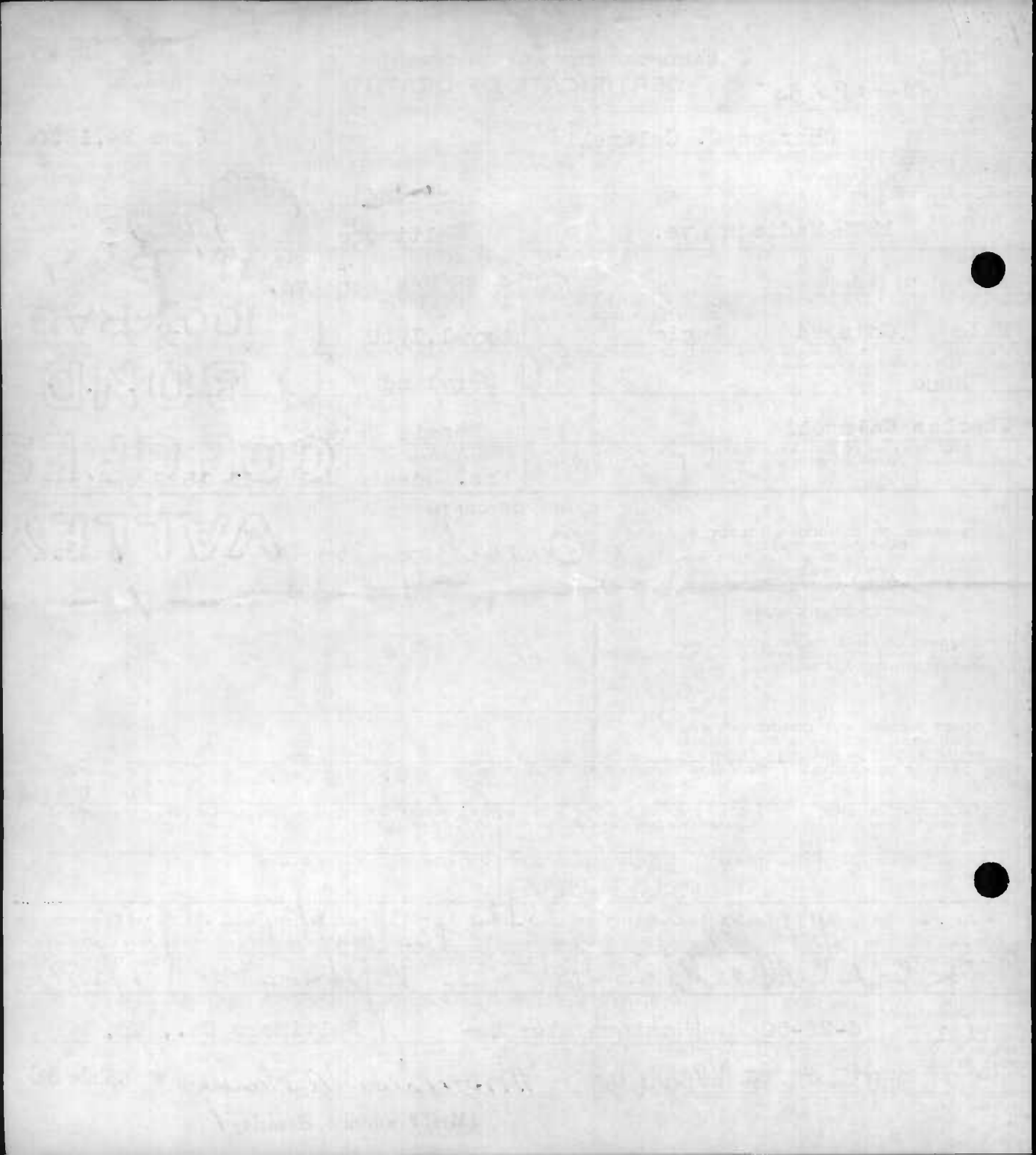
JUN 26 1950

Huntington Williams, M.D.

Mrs. Frances A. Hemsley

578 W. Biddle St





234

0 5619

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5619

Registered No.

BIRTH NO.

|  |                                  |   |  |  |  |
|--|----------------------------------|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>JOHN EDWARD LECHTHALER</b>   |                                  |   | 2. DATE OF DEATH<br><b>6-23-50</b>   |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>BALT.</b> |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b> |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTIMORE -18 9-06</b>                                |  |  |
| D. STREET ADDRESS (If rural, give location)<br><b>1509 E. 33RD ST.</b>   |                                  |   |  |  |  |
| c. Length of stay in Baltimore <b>66 YRS</b>   |                                  |   | Yrs. Mos. Days   |  |  |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>MARRIED</b> | 8. DATE OF BIRTH<br><b>8-20-1883</b>   |  | 9. AGE (In years last birthday)<br><b>66</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>BUSINESSMAN</b>                              |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>PRESSING EQPT.</b>        | 11. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE, MD.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |
| 13. FATHER'S NAME<br><b>JOHN A. LECHTHALER</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>MATILDA MILLER</b>  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>NO</b>   |                                  | 16. SOCIAL SECURITY NO.   | 17. INFORMANT (WIFE) ADDRESS<br><b>MARY C. LECHTHALER SAME</b>   |  |  |

MEDICAL CERTIFICATION

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 18. <b>193X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>GILOBLASTOMA of RT TESTIS</b>         |  | CAUSE OF DEATH<br>(A) <b>GILOBLASTOMA of RT TESTIS</b><br>DUE TO <b>LOVE</b><br>(B) _____<br>DUE TO _____<br>(C) _____ |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>T. RU-PIRIAL</b>   |  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.        |  |   |  |
| 19A. DATE OF OPERATION<br><b>6-14-50</b>  |  | 19B. MAJOR FINDINGS OF OPERATION<br><b>GILOBLASTOMA of RT TESTIS</b>   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>              |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>JUNE 7</b> , 1950, to <b>JUNE 23</b> , 1950, that I last saw the deceased alive on <b>JUNE 23</b> , 1950, and that death occurred at <b>9:25 PM</b> , from the causes and on the date stated above. |  |  |  |   |  |
| 23A. SIGNATURE<br><b>Dr. [Signature]</b>  |  | 23B. ADDRESS<br><b>[Signature]</b>   |  | 23C. DATE SIGNED<br><b>6-24-50</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>June 27, 50</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>                      |  |
| 24D. LOCATION (City, town or county) (State)<br><b>Baltimore Md.</b>  |  | 24E. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Md.</b>   |  | 24F. LOCATION (City, town or county) (State)<br><b>Baltimore Md.</b>                |  |
| 24G. DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 26 1950</b>   |  | 24H. REGISTRAR'S SIGNATURE<br><b>Wm. [Signature]</b>   |  | 24I. FUNERAL DIRECTOR<br><b>HENRY SANDER &amp; SONS, INC.</b>                       |  |
| 24J. ADDRESS<br><b>Baltimore Md.</b>  |  | 24K. ADDRESS<br><b>Baltimore Md.</b>   |  | 24L. ADDRESS<br><b>Baltimore Md.</b>  |  |



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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5620

BIRTH NO. 5620

|   |                              |   |   |
|---|------------------------------|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Agnes M. Reifschneider</b>  |                              | 2. DATE OF DEATH <b>6-23-50</b>   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>Maryland General Hospital</b>  |                              | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>8-05</b>                |   |
| D. STREET ADDRESS (If rural, give location)<br><b>2007 North Wolfe St #13</b>   |                              | E. Yrs. Mos. Days<br><b>73</b>  |   |
| 5. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b>   | 8. DATE OF BIRTH<br><b>12/15/1876</b>   |
| 9. AGE (In years last birthday)<br><b>73</b>  |                              | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>              | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>   |                              | 13. FATHER'S NAME<br><b>EILERT MORHFELD</b>   |   |
| 14. MOTHER'S MAIDEN NAME  |                              | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)   |   |
| 16. SOCIAL SECURITY NO.   |                              | 17. INFORMANT ADDRESS<br><b>Mrs. Philip Wagner (daughter)</b>   |   |
| 18. <b>443X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Cerebrovascular accident</b><br>DUE TO<br><b>Hypertensive cardiovascular disease</b><br>DUE TO<br><b>Antecedent causes</b><br>DUE TO<br><b>Other significant conditions contributing to the death, but not related to the disease or condition causing it.</b> |                              |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>24 days</b><br><b>thru</b><br><b>about</b><br><b>5 years</b> |
| 19A. DATE OF OPERATION  |                              | 19B. MAJOR FINDINGS OF OPERATION  |   |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                              | 21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |                              | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                                   |   |
| 21C. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                              | 21D. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                      |   |
| 21E. HOW DID INJURY OCCUR?  |                              | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I hereby certify that I attended the deceased from <b>6-4, 1950</b> to <b>6-23, 1950</b> that I last saw the deceased alive on <b>6-23, 1950</b> and that death occurred at <b>945 PM</b> , from the causes and on the date stated above.   |                              |   |   |
| 23A. SIGNATURE<br><b>Marygrove Louise Cudde</b>   |                              | 23B. ADDRESS<br><b>Maryland General Hosp.</b>   |   |
| 23C. DATE SIGNED<br><b>6-25-50</b>  |                              | 24A. BURIAL, CREMATION, REMOVAL (Specify)   |   |
| 24B. DATE<br><b>June-26-50</b>  |                              | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Carmel</b>   |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Md</b>  |                              | 25. FUNERAL DIRECTOR<br><b>H. Lander + Sons, Balto. Md.</b>   |   |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 26 1950</b>  |                              | REGISTRAR'S SIGNATURE<br><b>Wilmington Williams, Md.</b>  |   |

MEDICAL CERTIFICATION

10-23-20

Agnes M. Richardson

Remitted from 2 months

to 1000 dollars

1000 dollars

Married

Mr. John J. (son)

Remitted from 2 months

to 1000 dollars

10-23-20

1000 dollars

Remitted from 2 months

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 5621

200  
5621  
BIRTH NO.

|   |                           |  |  |  |  |
|---|---------------------------|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Millicent B. WAYS</b>   |                           |  |  | 2. DATE OF DEATH <b>June 25, 1950</b>  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                           |  |  | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>Baltimore City</b> |  |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL</b>   |                           |  |  | C. CITY OR TOWN <b>Baltimore</b> (If outside corporate limits, write R.U.R. and give township)<br><b>19-04</b>                               |  |
| 6. Length of stay in Baltimore <b>8 yrs.</b>  |                           |  |  | D. STREET ADDRESS (If rural, give location)<br><b>327 S. Fulton Ave.</b>   |  |
| 5. SEX <b>M.</b>  | 6. COLOR OR RACE <b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>  |  | 8. DATE OF BIRTH <b>Mar. 8, 1909</b>   | 9. AGE (In years last birthday) <b>41</b>  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Packer</b>   |                           | 10B. KIND OF BUSINESS OR INDUSTRY <b>Baker's Dept. Co.</b>   |  | 11. BIRTHPLACE (State or foreign country) <b>MD.</b>   |  |
| 13. FATHER'S NAME <b>Herbert WAYS</b>   |                           |  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>  |                           |  |  | 16. SOCIAL SECURITY NO. <b>215-24-8222</b>   |  |
| 17. INFORMANT <b>Herbert WAYS</b>   |                           |  |  | ADDRESS <b>Manorville, Md.</b>   |  |
| 18. <b>570.5</b> CAUSE OF DEATH   |                           |  |  |  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  |                           |  |  |  |  |
| (A) <b>Multiple small intestinal fistulae approx. 4 yrs.</b>  |                           |  |  |  |  |
| DUE TO  |                           |  |  |  |  |
| ANTECEDENT CAUSES   |                           |  |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |                           |  |  |  |  |
| (B) <b>Peritonitis</b>  |                           |  |  |  |  |
| DUE TO  |                           |  |  |  |  |
| (C) <b>Small Intestine due to adhesions</b>   |                           |  |  |  |  |
| II  |                           |  |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                           |  |  |  |  |
| 19A. DATE OF OPERATION <b>6/9/50</b>  |                           | 19B. MAJOR FINDINGS OF OPERATION <b>Peritonitis with perforation of small intestine</b>                |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                           | 21B. PLACE OF INJURY (e.g., home or about home, farm, factory, street, office bldg, etc.)              |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |                           | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <b>6/19/1950</b> to <b>6/25/1950</b> , that I last saw the deceased alive on <b>6/25/1950</b> , and that death occurred at <b>11:05 AM</b> , from the causes and on the date stated above. |                           |  |  |  |  |
| 23A. SIGNATURE <b>Howard W. Parr</b>  |                           | M. D. <b>know (Imp. of Balto.)</b>   |  | 23C. DATE SIGNED <b>6/25/50</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                           | 24B. DATE <b>6-28-50</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY <b>Springfield</b>  |  |
| 24D. LOCATION (City, town, or county) <b>Hydenville, Cecil Md.</b>  |                           | (State) <b>Md.</b>   |  | 25. FUNERAL DIRECTOR <b>C. Harry Eber - Hydenville, Md.</b>  |  |
| DATE RECEIVED BY LOCAL REGISTRAR <b>JUN 26 1950</b>   |                           | REGISTRAR'S SIGNATURE <b>Wilmington Williams, Md.</b>  |  | ADDRESS <b>Hydenville, Md.</b>   |  |

MEDICAL CERTIFICATION

496XV

122B

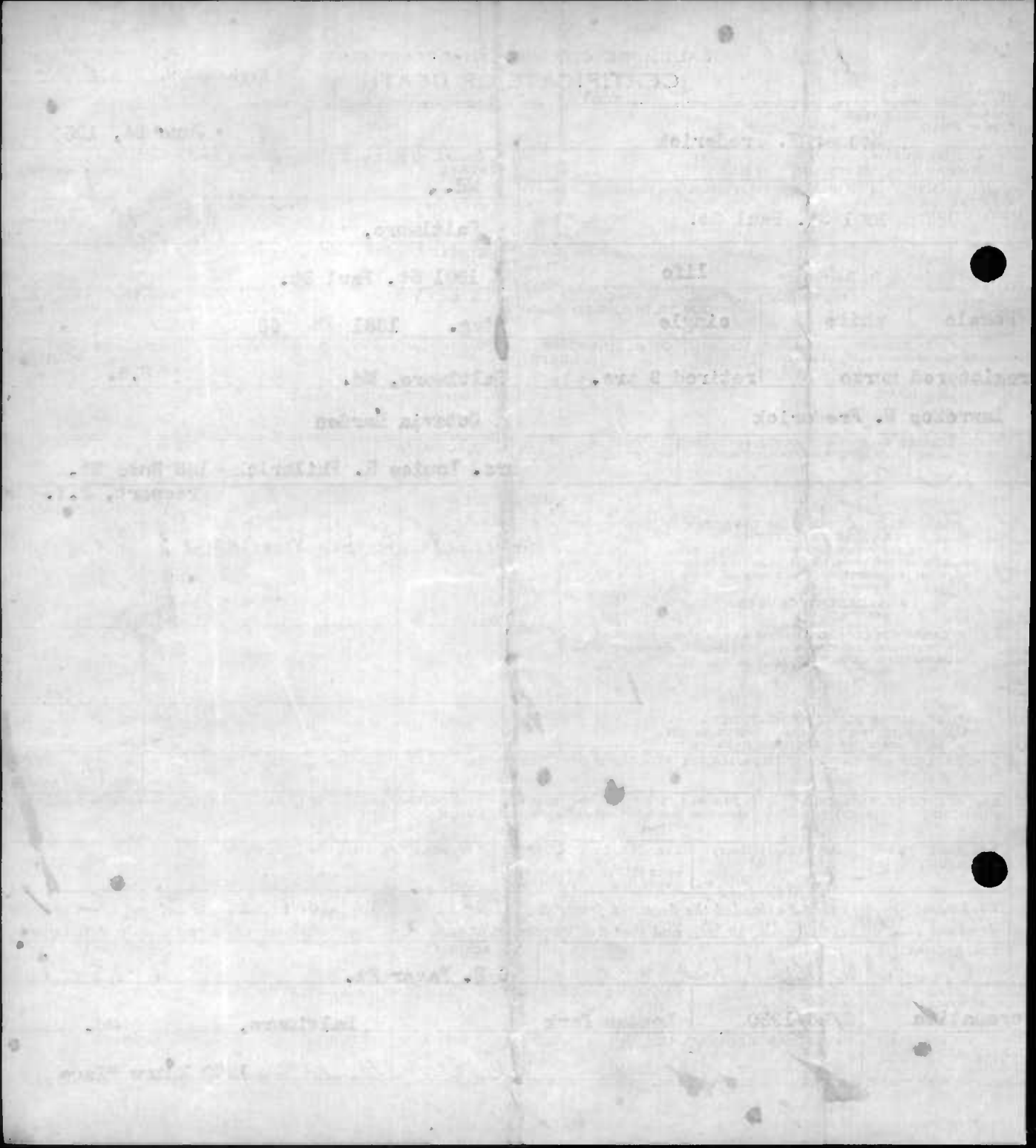


29

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 5622**

|   |   |   |  |  |  |
|---|---|---|--|--|--|
| BIRTH NO. <b>5622</b>   |   | 1. NAME OF DECEASED<br>(Type or Print) <b>Hester K. Frederick</b>   |  | 2. DATE OF DEATH <b>June 24, 1950</b>  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>11-01</b> |  |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>1001 St. Paul St.</b>  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore,</b>                                   |  |  |  |
| C. Length of stay in Baltimore <b>life</b>  |   | D. STREET ADDRESS (If rural, give location)<br><b>1001 St. Paul St.</b>   |  |  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>white</b>  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>single</b>  | 8. DATE OF BIRTH<br><b>Aug. 1881</b>                                   |  | 9. AGE (In years last birthday)<br><b>68</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>registered nurse</b>  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>retired 9 yrs.</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>                   |  |
| 13. FATHER'S NAME<br><b>Lawrence N. Frederick</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>no</b>  |   | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS<br><b>Mrs. Louise R. Philbrick 168 Rose St. Freeport, N.Y.</b> |  |
| 18. <b>4720.0</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Arterio-Sclerotic Heart Disease</b>      |   | CAUSE OF DEATH  |  | BETWEEN ONSET AND DEATH<br><b>? one week</b>   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |   | (B)   |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |   | (C)   |  |  |  |
| 19A. DATE OF OPERATION  |   | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |  |  |  |
| 22. I hereby certify that I attended the deceased from <b>April 1, 1950</b> to <b>JUNE 24, 1950</b> ; that I last saw the deceased alive on <b>JUNE 24, 1950</b> , and that death occurred at <b>about 11 a. m.</b> , from the causes and on the date stated above. |   |   |  |  |  |
| 23A. SIGNATURE<br><b>Crawford N. Kishpatrick, Jr.</b>   |   | 23B. ADDRESS<br><b>6 E. Eager St.</b>   |  | 23C. DATE SIGNED<br><b>6-25-50</b>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>cremation</b>   | 24B. DATE<br><b>6/26/1950</b>   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b> |  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 26 1950</b>  | REGISTRAR'S SIGNATURE<br><b>William H. Williams, M.D.</b>   | 25. FUNERAL DIRECTOR<br><b>John O. Mitchell &amp; Sons</b>  |  | ADDRESS<br><b>1900 Eutan Place</b>   |  |



645  
0 5623

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5623  
Registered No.

|   |  |   |   |
|---|--|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Anna Perlman</i>  |  | 2. DATE OF DEATH <i>6-25-50</i>   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>MD</i><br>B. COUNTY <i>15-11</i> |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Senai Hosp</i>   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto.</i>  |   |
| C. Length of stay in Baltimore <i>55</i>  |  | D. STREET ADDRESS (If rural, give location) <i>3501 Calloway Ave</i>  |   |
| 5. SEX <i>Female</i>  | 6. COLOR OR RACE <i>White</i>  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>  | 8. DATE OF BIRTH <i>66</i>                                      |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Work</i>   |  | 10B. KIND OF BUSINESS OR INDUSTRY   |   |
| 13. FATHER'S NAME <i>Solomon</i>  |  | 11. BIRTHPLACE (State or foreign country) <i>Russia</i>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |  | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>  |   |
| 16. SOCIAL SECURITY NO.   |  | 14. MOTHER'S MAIDEN NAME <i>Rose</i>  |   |
| 17. INFORMANT <i>Mr. Meyer Levi</i>   |  | ADDRESS <i>-3501 Calloway Ave</i>   |   |
| 18. <i>47010</i> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Prob myocardial Infarction</i><br>DUE TO<br><i>HAS HD</i><br>DUE TO<br><i>Prob Pulm Infarction</i><br>DUE TO<br><i>II</i><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  |   |   |
| 19A. DATE OF OPERATION <i>0</i>   |  | 19B. MAJOR FINDINGS OF OPERATION  |   |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |   |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I hereby certify that I attended the deceased from <i>6-7</i> , 19 <i>50</i> , to <i>6-25</i> , 19 <i>50</i> that I last saw the deceased alive on <i>6/25</i> , 19 <i>50</i> , and that death occurred at <i>2:15</i> p.m., from the causes and on the date stated above.  |  |   |   |
| 23A. SIGNATURE <i>Leonard Rose</i>  |  | 23B. ADDRESS <i>Senai Hosp</i>  | 23C. DATE SIGNED <i>6-25-50</i>                                 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>   | 24B. DATE <i>6/27/1950</i>   | 24C. NAME OF CEMETERY OR CREMATORY <i>Rosehill</i>  | 24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i> |
| DATE RECEIVED BY LOCAL REGISTRAR <i>JUN 26 1950</i>   |  | REGISTRAR'S SIGNATURE <i>Frank Lewis</i>  |   |
| 25. FUNERAL DIRECTOR <i>Frank Lewis</i>   |  | ADDRESS <i>2100 Eutaw PL</i>  |   |

MEDICAL CERTIFICATION

77087

93D

STATE OF NEW YORK  
CERTIFICATE OF DEATH

Blank form with horizontal lines for text entry.

152

5624

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5624

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HANNAH ROBINSON

2. DATE  
OF  
DEATH

6-25-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

4203 Springdale Ave Baltimore 15-09

C. Length of stay in Baltimore

60 Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)  
Widow

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

George Stumberg

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

Yes, no or unknown

16. SOCIAL SECURITY NO.

8. DATE OF BIRTH

9. AGE (In years last birthday)

11 Under 1 Year

11 Under 24 Hours

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

U.S.B.

14. MOTHER'S MAIDEN NAME

Ida

17. INFORMANT

ADDRESS

George Robinson 3513 Springdale Ave

18. 331X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

cerebral hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

12 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

arteriosclerosis

(C)

Hypertension

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

TIME (Month) (Day) (Year) (Hour)

INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 30/1949, to June 25, 1950, that I last saw the deceased alive on June 25, 1950, and that death occurred at 6:27 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Samuel Whitestone

M. D.

23B. ADDRESS

1720 Euth Pl.

23C. DATE SIGNED

6/26/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

6/26/50

24C. NAME OF CEMETERY OR CREMATORY

Beth Tfeloh

24D. LOCATION (City, town, or county)

Balt.

(State)

Md.

DATE RECEIVED BY LOCAL REGISTRAR

JUN 26 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Jack Lewis Inc - 2100 Eutaw Pl

ADDRESS



Whitchones  
1720 E. Guitard Pl  
Law 1129 9AM

142

Loveless

50 5625

## BALTIMORE CITY HEALTH DEPARTMENT

## T. CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

3. PLACE OF DEATH:

A. Baltimore City, Maryland 2405 E. Oliver St

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

C. Length of stay in Baltimore

5. SEX Male 6. COLOR OR RACE White 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assembler 10B. KIND OF BUSINESS OR INDUSTRY Dried May Oil Surveys

13. FATHER'S NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

8. DATE OF BIRTH

9. AGE (in years, last birthday)

11. Under 1 Year Months: Days 12. Under 24 Hours Hours: Min.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

17. INFORMANT

ADDRESS

18.

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

## ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

TIME (Month) (Day) (Year) (Hour)

INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 15, 1950, to June 24, 1950, that I last saw the deceased alive on June 23, 1950, and that death occurred at 7A m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUN 26 1950

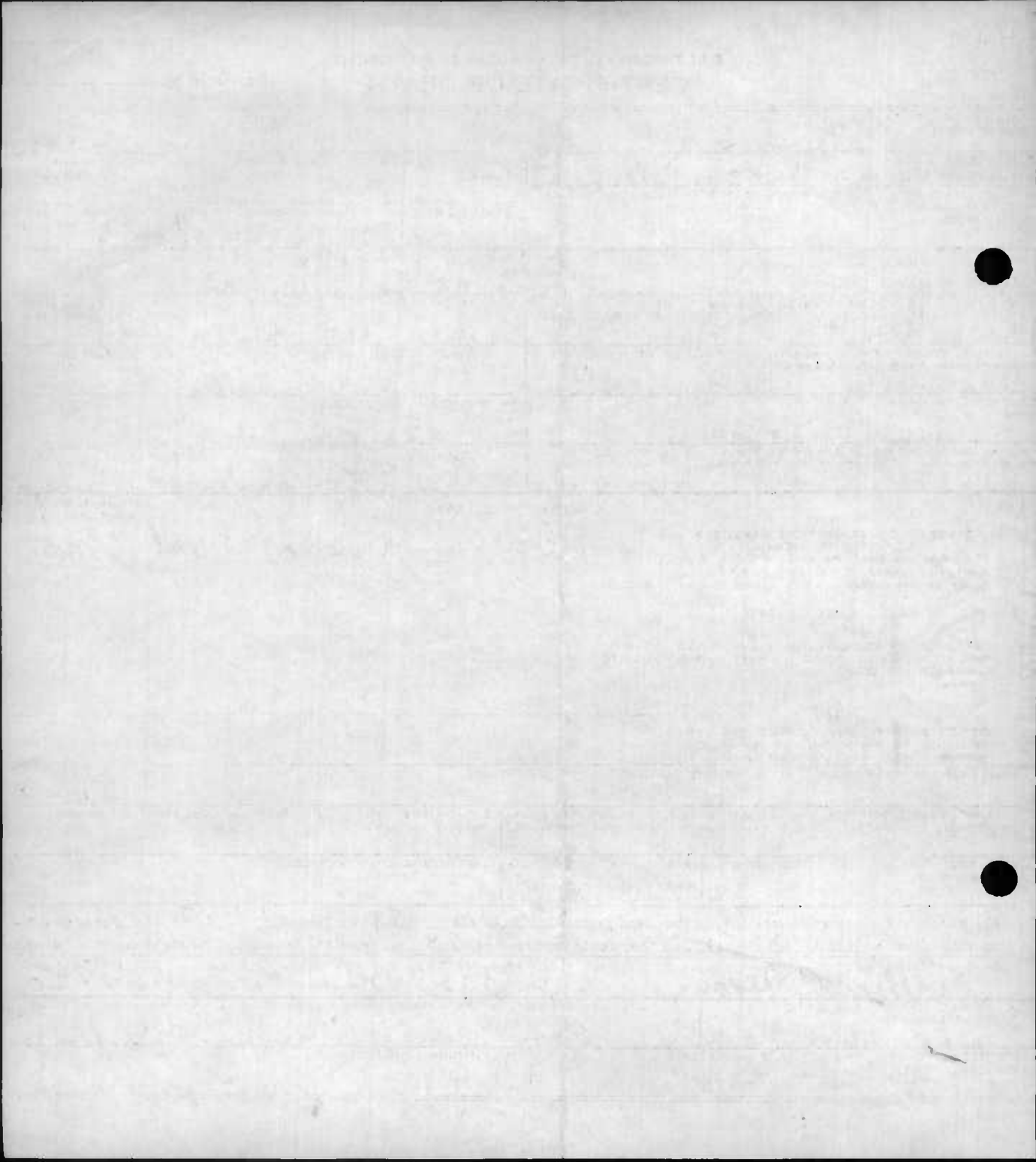
Thurston William

John C. Miller Inc - 2435 E. Oliver St

VS 150

49630

46M



325

5626

CERTIFICATE CORRECTED 7-26-50

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5626

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

C. EARL WATSON

2. DATE  
OF  
DEATH

June 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR  
INSTITUTION 2222 Callow Ave.

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2222 Callow Ave.

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Aug. 5, 1877

9. AGE (In years  
last birthday)

72 44

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Plant Foreman (rtd)

10B. KIND OF BUSINESS OR  
INDUSTRY

Auto Mfg

13. FATHER'S NAME

Alexander Watson

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF  
WHAT COUNTRY?15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

no

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Arnold Klein

2222 Callow Ave.

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Coronary Occlusion

36 hrs.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Arteriosclerosis

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 24, 1950, to June 25, 1950, that I last saw the  
deceased alive on June 25, 1950, and that death occurred at 7 P. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Removal

24B. DATE

6/26/50

24C. NAME OF CEMETERY OR CREMATORY

Rural C em.

24D. LOCATION (City, town, county)

Poughkeepsie, New York

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUN 26 1950

Wilmington Williams, Md

Wm. J. McKenney &amp; Sons, Balto

VS 150

31639

94a

md

MEDICAL CERTIFICATION

UNITED STATES DEPARTMENT OF HEALTH

STATISTICS AND RESEARCH

CERTIFICATE OF DEATH

IN THE DISTRICT OF COLUMBIA

For the year ending December 31, 19

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

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PREVIOUS OTHER

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PREVIOUS OTHER

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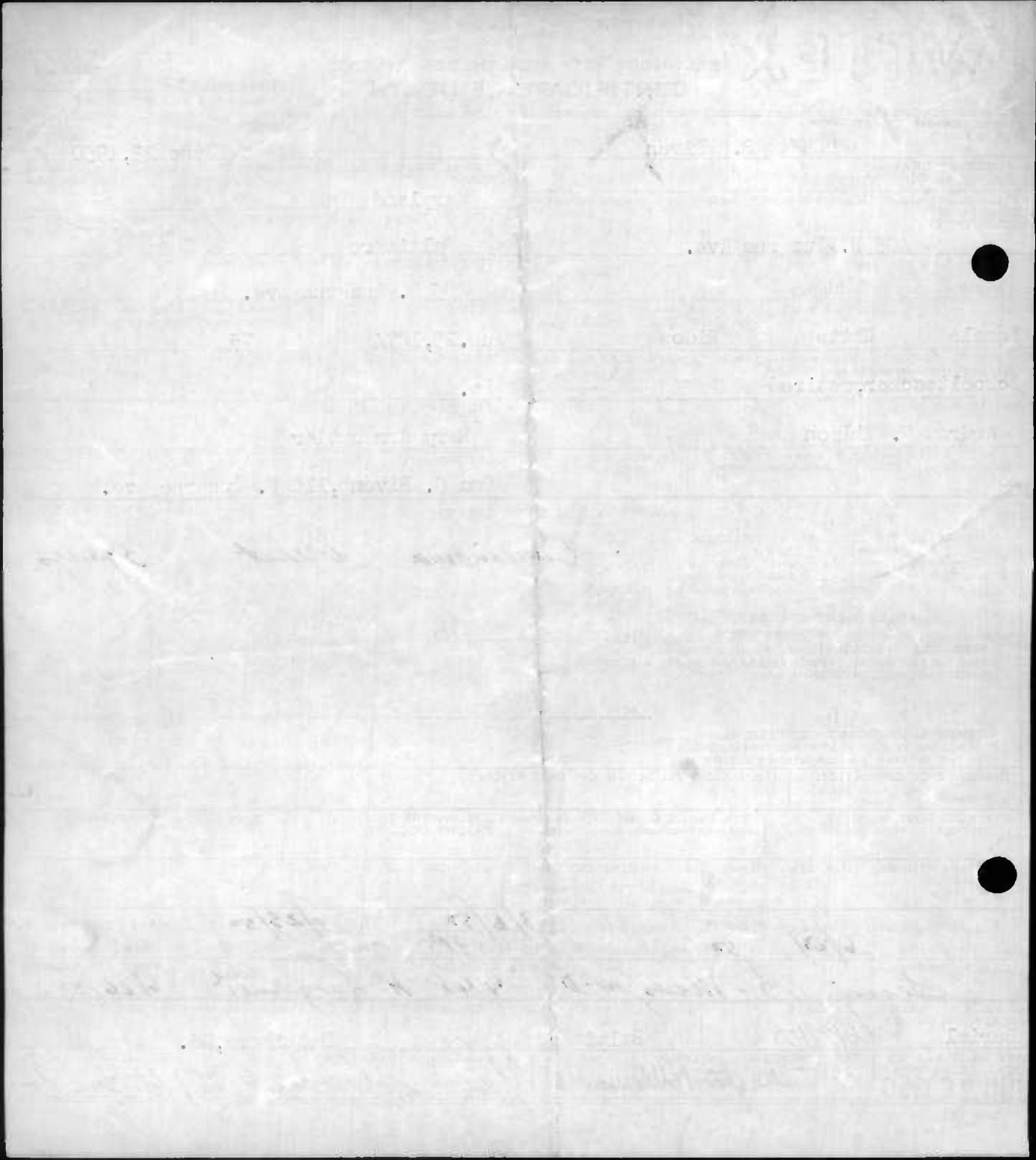
150  
5627BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5627  
Registered No.

BIRTH NO.

|   |                                  |   |   |  |   |
|---|----------------------------------|---|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>DONNA B. Biven</b>  |                                  |   | 2. DATE OF DEATH <b>June 23, 1950</b>   |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>Baltimore</b> |  |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>405 N. Luzerne Ave.</b>            |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>  |  |   |
| C. Length of stay in Baltimore<br>Yrs.<br>Mos.<br>Days  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>405 N. Luzerne Ave.</b>   |  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widow</b> | 8. DATE OF BIRTH<br><b>Aug. 23, 1874</b>  | 9. AGE (in years last birthday)<br><b>75</b> | 10. Under 1 Year<br>Months: Days<br>11. Under 24 Hours<br>Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>School teacher, retired</b> |                                  |   | 10B. KIND OF BUSINESS OR INDUSTRY   |  |   |
| 11. FATHER'S NAME<br><b>Andrew F. Wilsoh</b>  |                                  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>Pa.</b>  |  |   |
| 13. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>No</b>                              |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Ann Butlar</b>  |  |   |
| 15. SOCIAL SECURITY NO.   |                                  |   | 16. INFORMANT ADDRESS<br><b>Oma G. Biven, 110 N. Luzerne Ave.</b>   |  |   |

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| 18. <b>170x</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Carcinoma - Breast</b><br>DUE TO<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>39 years</b> |  |  |   |  |  |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |  |   |  |  |
| 19A. DATE OF OPERATION <b>0</b>  |  |  | 19B. MAJOR FINDINGS OF OPERATION  |  |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |   |  |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) |  |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  | 21D. HOW DID INJURY OCCUR?  |  |  |
| 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21F. HOW DID INJURY OCCUR?  |  |  |
| 22. I hereby certify that I attended the deceased from <b>3/6/50</b> , 19 <b>50</b> , to <b>6/23/50</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>6/23/50</b> , 19 <b>50</b> , and that death occurred at <b>9P.</b> m., from the causes and on the date stated above.                           |  |  |   |  |  |
| 23A. SIGNATURE<br><b>Berni B. Moss, M.D.</b>   |  |  | 23B. ADDRESS<br><b>448 N. Luzerne Ave</b>   |  |  |
| 23C. DATE SIGNED<br><b>6/26/50</b>   |  |  |   |  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  | 24B. DATE<br><b>6/27/50</b>   |  |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore</b>   |  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>                    |  |  |
| 25. FUNERAL DIRECTOR<br><b>Wm. Cook, Inc. - 1217 N. Paul St.</b>   |  |  | 26. ADDRESS<br><b>1217 N. Paul St.</b>  |  |  |





300

50 5628

Schott  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5628

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Lewis Charles Schott

2. DATE  
OF  
DEATH

6-24-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived: If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (if rural, give location)

901 W. Bradford St.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

St. Joseph's Hospital

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Sheet Metal Worker Elec (M.)

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Joseph Schott

14. MOTHER'S MAIDEN NAME

Mary Bublik

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

214-03-1647

17. INFORMANT

ADDRESS

William Schott 901 W. Bradford

18. 199.8

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Carcinomatous

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Primary site unknown.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)

INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/13/50, to 6/24/50, that I last saw the deceased alive on 6/24/50, and that death occurred at 6:40 P.M.; from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUN 26 1950

Thurston Williams, Jr.

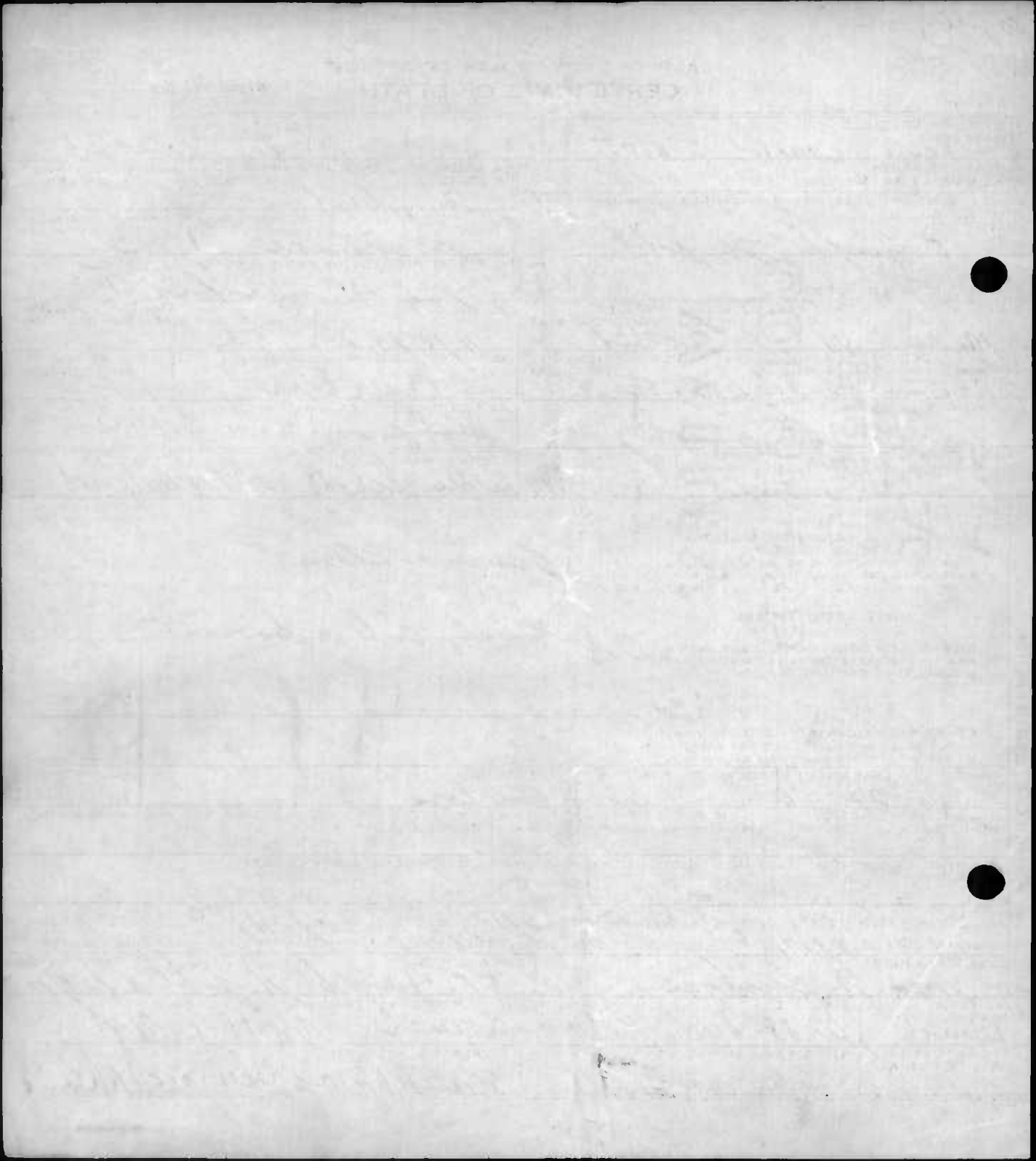
Frank Brachman 8009 Ashland

VS 150

36235

55E

MEDICAL CERTIFICATION



DB-159012  
50 5629  
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

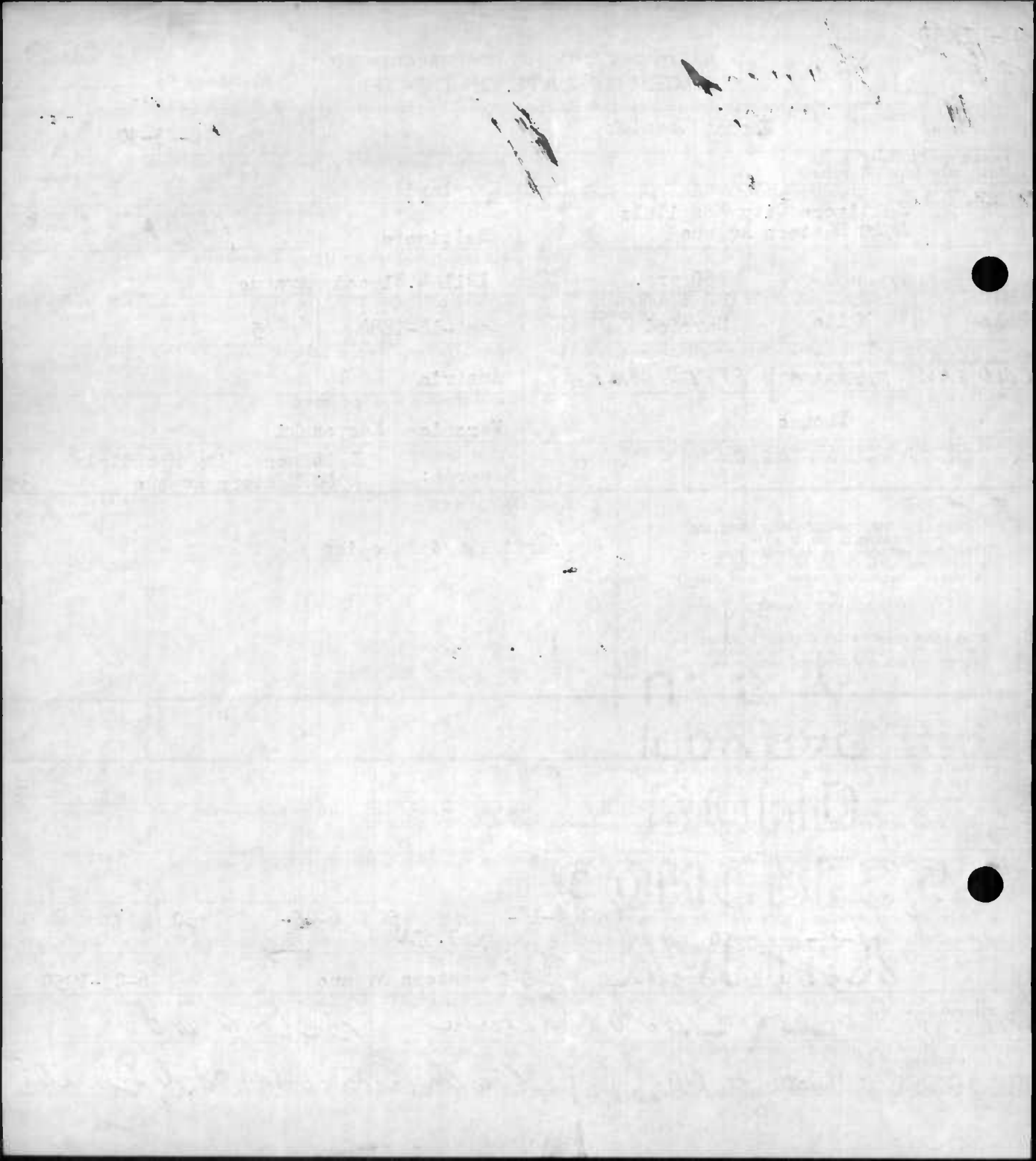
50 5629  
Registered No.

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Thomas Lesnick</b>  |                                  | 2. DATE OF DEATH<br><b>6-25-50</b>   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>Baltimore City Hospitals</b><br><b>4940 Eastern Avenue</b> |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>1-01</b>                   |   |
| C. Length of stay in Baltimore <b>50 yrs.</b><br>Yrs. Mos. Days   |                                  | D. STREET ADDRESS (If rural, give location)<br><b>1211 S. Elwood Avenue</b>  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>  | 8. DATE OF BIRTH<br><b>Sept-12-1884</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>COLD SAW OPERATOR</b>                               |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>STEEL MILLS</b>  |   |
| 13. FATHER'S NAME<br><b>Thomas</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Veronica Kacvenski</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)<br>Yes, oo or unkoowo  |                                  | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT<br><b>Baltimore City Hospitals</b><br><b>Records:</b> <b>4940 Eastern Avenue</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?   |   |

|   |  |                                  |
|---|--|----------------------------------|
| 18. <b>420.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Myocardial infarction</b><br>DUE TO<br>(A) <b>Myocardial infarction</b><br>(B)<br>(C)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B)<br>(C)<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  | INTERVAL BETWEEN ONSET AND DEATH |
|---|--|----------------------------------|

|   |  |  |   |   |  |
|---|--|--|---|---|--|
| 19A. DATE OF OPERATION <b>6-25-50</b>   |  | 19B. MAJOR FINDINGS OF OPERATION   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  | 21B. PLACE OF INJURY (e.g., io or about home, farm, factory, street, office bldg., etc.)               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |   |  |
| 22. I hereby certify that I attended the deceased from <b>6-18-</b> <b>1950</b> , to <b>6-25-</b> <b>1950</b> , that I last saw the deceased alive on <b>6-25-</b> <b>1950</b> , and that death occurred at <b>3:53AM</b> , from the causes and on the date stated above. |  |  |   |   |  |
| 23A. SIGNATURE<br><b>J. S. Cohen</b><br>M.D.  |  | 23B. ADDRESS<br><b>4940 Eastern Avenue</b>                               |   | 23C. DATE SIGNED<br><b>6-25-1950</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 24B. DATE<br><b>6-28-50</b>  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>               | 24D. LOCATION (City, town, or county) (State)<br><b>Bald 6 Md</b> |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 26 1950</b>  |  | REGISTRAR'S SIGNATURE<br><b>Wm. H. Williams</b>                          |   | 25. FUNERAL DIRECTOR ADDRESS<br><b>Health Care Center 9006 Lehigh</b>               |  |

VS 150  
352 29  
94a



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5630  
Registered No. \_\_\_\_\_

|  |                                    |  |   |
|--|------------------------------------|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>ESTELLA G. GRAVES</b>  |                                    | 2. DATE OF DEATH <b>June 23, 1950</b>  |   |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>   |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY _____ |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Franklin Square Hospital</b>                                     |                                    | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>                                     |   |
| C. Length of stay in Baltimore<br>Yrs. _____<br>Mos. _____<br>Days _____                                       |                                    | D. STREET ADDRESS (If rural, give location)<br><b>219 N. Calhoun Street</b>  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>Colored</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Single</b>   | 8. DATE OF BIRTH<br><b>Oct. 3, 1889</b>   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Domestic</b> |                                    | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>at Home</b>  | 9. AGE (In years last birthday) <b>61</b><br>If Under 1 Year: Months: _____ Days: _____<br>If Under 24 Hours: Hours: _____ Min: _____ |
| 13. FATHER'S NAME<br><b>William Graves</b>   |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>                                     |                                    | 16. SOCIAL SECURITY NO. _____  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Amanda Thomas</b>   |                                    | 17. INFORMANT<br><b>Dorothy P. Scott</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>                                     |                                    | ADDRESS _____  |   |

|   |  |                                  |
|---|--|----------------------------------|
| 18. <b>260X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Diabetes mellitus with ischiorectal abscess</b> |  | INTERVAL BETWEEN ONSET AND DEATH |
| (A) _____   |  |                                  |
| (B) _____   |  |                                  |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(C) _____   |  |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATING TO THE DISEASE OR CONDITION CAUSING IT.  |  |                                  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 19A. DATE OF OPERATION _____  |  | 19B. MAJOR FINDINGS OF OPERATION _____  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____      |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR? _____  |  |
| 22. I certify that I took charge of the remains described above, held an <b>Inspection &amp; Inquiry</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <b>natural causes</b> <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |  |   |  |   |  |
| 23A. SIGNATURE<br><b>R. B. Fisher</b>   |  | 23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/> |  | 23C. DATE SIGNED<br><b>June 24, 1950</b>  |  |

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> |  | 24B. DATE<br><b>6/28/50</b>                               |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Mt Auburn</b> |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md</b> |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 26 1950</b>     |  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b> |  | 25. FUNERAL DIRECTOR<br><b>Joseph A. Lively</b>        |  | ADDRESS<br><b>661 W. Park</b>   |  |

**52086**

**61**

MEDICAL CERTIFICATION



BRANDSHEIM CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

FILE NO.

NAME

TOTAL NO. OF DEATHS

CAUSE OF DEATH

AGE

SEX

RACE

DEATH CERTIFICATE NO. \_\_\_\_\_  
DATE OF DEATH \_\_\_\_\_

PLACE OF DEATH \_\_\_\_\_

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

RELIGION

OCCUPATION

STATUS

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

-600

0 5631

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5631

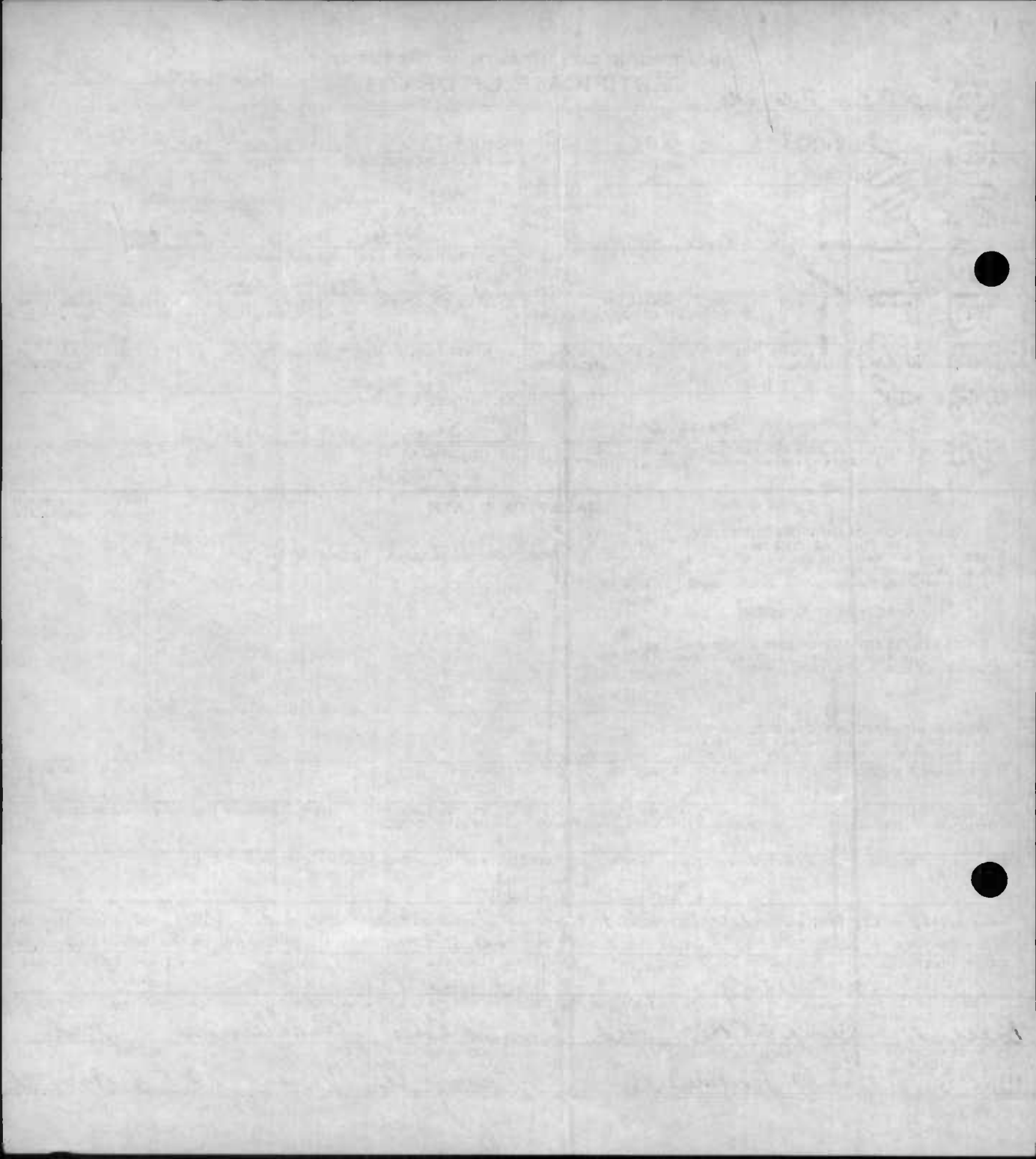
Registered No.

|  |                       |   |                          |  |  |
|--|-----------------------|---|--------------------------|--|--|
| BIRTH NO.  |                       | 1. NAME OF DECEASED<br>(Type or Print)  |                          | 2. DATE OF DEATH   |  |
|  |                       | MURRAY, Augustis Harry  |                          | 6-22-50  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                       | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)<br>A. STATE Md. B. COUNTY |                          |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>UNIVERSITY Hospital   |                       | C. CITY OR TOWN (If outside corporate limits, write full name and give township)<br>Baltimore 22-05             |                          |  |  |
| C. Length of stay in Baltimore<br>62 Yrs. Mos. Days  |                       | D. STREET ADDRESS (If rural, give location)<br>537 W Conway St.   |                          |  |  |
| 5. SEX<br>m  | 6. COLOR OR RACE<br>C | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>W  | 8. DATE OF BIRTH<br>1888 | 9. AGE (In years last birthday)<br>62                                    | 10. Under 1 Year Months; Days 11. Under 24 Hours Hours; Min.             |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                       | 10B. KIND OF BUSINESS OR INDUSTRY   |                          | 11. BIRTHPLACE (State or foreign country)<br>Md.                         |  |
| 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |                       | 13. FATHER'S NAME<br>James Murray   |                          | 14. MOTHER'S MAIDEN NAME<br>Mary Stewart                                 |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br>Unknown   |                       | 16. SOCIAL SECURITY NO.   |                          | 17. INFORMANT ADDRESS<br>Carrie Jordan 713 Eiden St                      |  |
| 18. 002X   |                       | CAUSE OF DEATH  |                          |  | INTERVAL BETWEEN ONSET AND DEATH   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                                  |                       | (A) general cachectic   |                          |  |  |
| ANTECEDENT CAUSES  |                       | (B) Pulmonary Tuberculosis  |                          |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |                       | (C) Bronchopneumonia  |                          |  |  |
| II   |                       | Cerebral arteriosclerosis   |                          |  |  |
| 19A. DATE OF OPERATION   |                       | 19B. MAJOR FINDINGS OF OPERATION  |                          |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |                       | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                       |                          | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   |                       | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>       |                          | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from 6-20 1950, to 6-22 1950, that I last saw the deceased alive on 6-20 1950, and that death occurred at 10 <sup>45</sup> P.m., from the causes and on the date stated above. |                       |   |                          |  |  |
| 23A. SIGNATURE<br>J. L. Phenebaugh Jr.   |                       | 23B. ADDRESS<br>University Hospital   |                          | 23C. DATE SIGNED<br>6-22-50  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  |                       | 24B. DATE<br>June 26/50   |                          | 24C. NAME OF CEMETERY OR CREMATORY<br>Jones Station Md                   |  |
| 24D. LOCATION (City, town, or county) (State)<br>AA Co Md  |                       | 24E. DATE RECEIVED BY LOCAL REGISTRAR<br>JUN 26 1950  |                          | 24F. REGISTRAR'S SIGNATURE<br>Wilmington Williams                        |  |
| 24G. FUNERAL DIRECTOR<br>Isaac L. Brown Son  |                       | 24H. ADDRESS<br>108 W Montg omery   |                          | 24I. 13B   |  |

✓  
-ward Street

James M. Mendenhall

161c



W-356  
50 5633BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

50 5633

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

FREDERICK W. WHITTEMORE

2. DATE  
OF  
DEATH

6-24-50.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

821 E. 22ND ST.

16 Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

SALESMAN -

10B. KIND OF BUSINESS OR  
INDUSTRY

DISTILLERY

13. FATHER'S NAME

B. WHITTEMORE

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

231-16-2917

8. DATE OF BIRTH

1865

9. AGE (In years  
last birthday)If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.12. CITIZEN OF  
WHAT COUNTRY?

11. BIRTHPLACE (State or foreign country)

Wis.

14. MOTHER'S MAIDEN NAME

(?) LOCKETT.

17. INFORMANT

ADDRESS

MRS LOTTIE M. WHITTEMORE 821 E. 22ND ST.

18. 4 yr. 1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) ...

DUE TO

myocardial infarction

4 days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) ...

DUE TO

Atherosclerosis

20 years

(C) ...

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 20, 1950 to June 24, 1950, that I last saw the  
deceased alive on 6-24-1950, and that death occurred at 10:30 P. M., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

800 W 33rd St.

23C. DATE SIGNED

6-24-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

6-28-50

24C. NAME OF CEMETERY OR CREMATORY

PRINCETON

24D. LOCATION (City, town, or county)

Wis.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

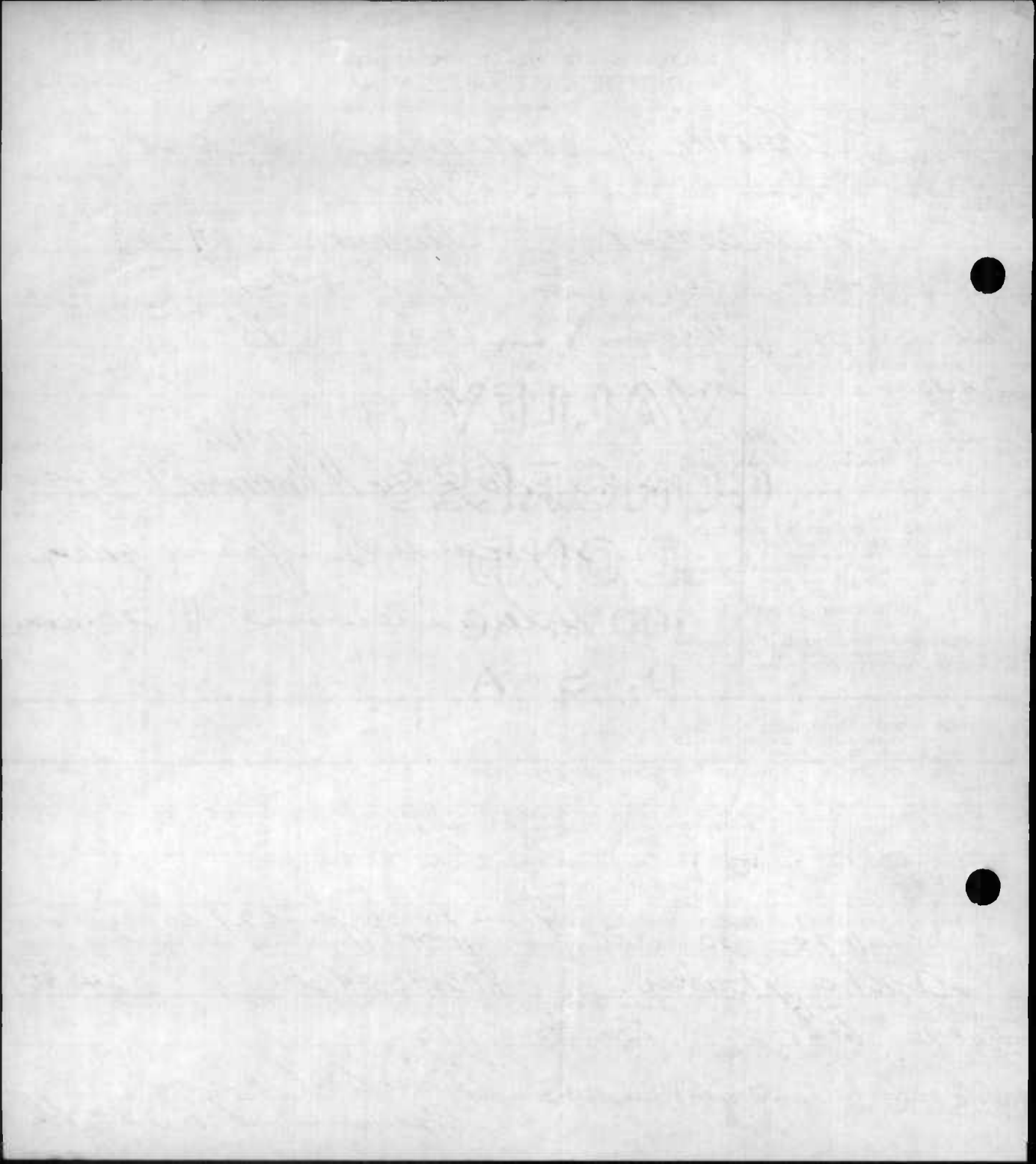
25. FUNERAL DIRECTOR

ADDRESS

Hendricks & Son 937  
Greenmount & 22nd St.

JUN 26 1950





| W-425 CERTIFICATE CORRECTED 8-22-50   |  |  |  | 50 5634        |                                    |
|---|--|--|--|----------------|------------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT  |  |  |  | 50 5634        |                                    |
| BIRTH NO.   |  |  |  | Registered No. |                                    |
| 1. NAME OF DECEASED<br>(Type or Print)  |  |  | 2. DATE OF DEATH   |                |                                    |
| James Leonard Wilson  |  |  | June 23-1950   |                |                                    |
| 3. PLACE OF DEATH:  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)    |                |                                    |
| A. Baltimore City, Maryland Balto. City   |  |  | A. STATE   |                |                                    |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)  |  |  | B. COUNTY  |                |                                    |
| HOSPITAL OR INSTITUTE   |  |  | Maryland   |                |                                    |
| Baltimore City Hospitals  |  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)             |                |                                    |
| 4940 Eastern Ave.   |  |  | Baltimore  |                |                                    |
| C. Length of stay in Baltimore  |  |  | D. STREET ADDRESS (If rural, give location)  |                |                                    |
| Life  |  |  | 805 N. Bond Street   |                |                                    |
| 5. SEX  |  |  | B. DATE OF BIRTH   |                |                                    |
| Male  |  |  | July 24-1906   |                |                                    |
| 6. COLOR OR RACE  |  |  | 9. AGE (In years last birthday)  |                |                                    |
| Negro   |  |  | 43   |                |                                    |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)   |  |  | 11. BIRTHPLACE (State or foreign country)  |                |                                    |
| Married   |  |  | Maryland   |                |                                    |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |  | 12. CITIZEN OF WHAT COUNTRY?   |                |                                    |
| Laborer   |  |  | (D)  |                |                                    |
| 13. FATHER'S NAME   |  |  | 14. MOTHER'S MAIDEN NAME   |                |                                    |
| John  |  |  | Unkown   |                |                                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)  |  |  | 17. INFORMANT ADDRESS  |                |                                    |
| No  |  |  | Baltimore City Hospitals   |                |                                    |
| 16. SOCIAL SECURITY NO.   |  |  | Records: 4940 Eastern Ave.   |                |                                    |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |  |  | CAUSE OF DEATH   |                |                                    |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  |  |  | (A) Subacute glomerular nephritis  |                |                                    |
| ANTECEDENT CAUSES   |  |  | DUE TO   |                |                                    |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  |  | (B)  |                |                                    |
|   |  |  | DUE TO   |                |                                    |
|   |  |  | (C)  |                |                                    |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |  | Metastatic carcinoma mesenteric nodes - primary site undetermined pulmonary tuberculosis |                |                                    |
| 19A. DATE OF OPERATION  |  |  | 19B. MAJOR FINDINGS OF OPERATION   |                |                                    |
| 0   |  |  |  |                |                                    |
| 20. AUTOPSY?  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                      |                |                                    |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  |  | 21B. PLACE OF INJURY (s.g., in or about home, farm, factory, street, office bldg., etc.) |                |                                    |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |  |  |                |                                    |
| 21D. TIME (Month) (Day) (Year) (Hour)   |  |  | 21E. INJURY OCCURRED   |                |                                    |
| 0   |  |  | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>        |                |                                    |
| 21F. HOW DID INJURY OCCUR?  |  |  |  |                |                                    |
| 22. I hereby certify that I attended the deceased from 5-18-1950 to 6-23-1950 that I last saw the deceased alive on 6-23-1950 and that death occurred at 5:45Pm., from the causes and on the date stated above. |  |  |  |                |                                    |
| 23A. SIGNATURE  |  |  | 23B. ADDRESS   |                | 23C. DATE SIGNED                   |
| J.S. Rogers   |  |  | 4940 Eastern Avenue  |                | June 24, 1950                      |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   |  |  | 24B. DATE  |                | 24C. NAME OF CEMETERY OR CREMATORY |
| Burial  |  |  | 6/26/1950  |                | Mt Galvery Cem.                    |
| 24D. LOCATION (City, town, or county) (State)   |  |  | 25. FUNERAL DIRECTOR ADDRESS   |                |                                    |
| Brooklyn A.A.Co.Md  |  |  | Elroy O. Wilson 1000 Brantly Ave   |                |                                    |
| DATE RECEIVED BY LOCAL REGISTRAR  |  |  | REGISTRAR'S SIGNATURE  |                |                                    |
| JUN 26 1950   |  |  | [Signature]  |                |                                    |
| 98881   |  |  | 1313   |                |                                    |

Please let us know if  
Cancer or Tuberculosis  
could have been the  
underlying cause  
of death

Letter in document file 50-5634-7/27/50.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 50-119 23

50 5635

|   |                             |  |  |  |  |
|---|-----------------------------|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) Baby Girl Dorothea Johnson                           |                             |  | 2. DATE OF DEATH June 23, 1950   |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                             |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE Md B. COUNTY C |  |  |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br>33 JOHNS HOPKINS HOSPITAL                        |                             |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 5-01                   |  |  |
| 6. Length of stay in Baltimore Life   |                             |  | D. STREET ADDRESS (If rural, give location)<br>4 N. Caroline St.   |  |  |
| 5. SEX<br>Female  | 6. COLOR OR RACE<br>Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Child | 8. DATE OF BIRTH<br>June 14-1950   |  | 9. AGE (in years last birthday)<br>35  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |                             | 10B. KIND OF BUSINESS OR INDUSTRY                        | 11. BIRTHPLACE (State or foreign country)<br>Baltimore   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A. |
| 13. FATHER'S NAME<br>Ernest Johnson   |                             |  | 14. MOTHER'S MAIDEN NAME<br>Grace Hendricke  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMY FORCES?<br>Yes, no or unknown<br>No                     |                             | 16. SOCIAL SECURITY NO.                                  | 17. INFORMANT<br>JOHNS HOPKINS HOSPITAL  |  |  |

|   |  |   |  |                                  |
|---|--|---|--|----------------------------------|
| 18. 767.0<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  | CAUSE OF DEATH<br>(A) Septicemia<br>DUE TO<br>(B) Ophthalmitis<br>DUE TO<br>(C) |  | INTERVAL BETWEEN ONSET AND DEATH |
|---|--|---|--|----------------------------------|

|  |   |  |  |   |
|--|---|--|--|---|
| 19A. DATE OF OPERATION<br>2  |   | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br><input type="checkbox"/>  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |   |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>O INJURY  | 21E. INJURY OCCURRED<br>WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK | 21F. HOW DID INJURY OCCUR?   |  |   |
| 22. I hereby certify that I attended the deceased from 6-23-1950 to 6-23-1950, that I last saw the deceased alive on 6-23-1950 and that death occurred at 2 P. m., from the causes and on the date stated above. |   |  |  |   |
| 23A. SIGNATURE<br>E. C. Robinson M. D.   |   | 23B. ADDRESS<br>JOHNS HOPKINS HOSPITAL                                   |  | 23C. DATE SIGNED<br>6-23-50   |

|   |                        |   |   |
|---|------------------------|---|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial | 24B. DATE<br>6/26/1950 | 24C. NAME OF CEMETERY OR CREMATORY<br>Mt Calvary Cem. | 24D. LOCATION (City, town, or county) (State)<br>Brooklyn A.A.Co.Md |
| DATE RECEIVED BY LOCAL REGISTRAR<br>JUN 26 1950     |                        | REGISTRAR'S SIGNATURE<br>Walter Williams, M.D.        | 25. FUNERAL DIRECTOR<br>Elroy O. Wilson 1000 Brantly Ave            |

Septococcus  
capitata

W. H. H. H.

254

5636

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5636

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Rev. Martin L. McNulty

2. DATE  
OF  
DEATH

6-24-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

Bon Secours Hosp.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

15-07B

C. Length of stay in Baltimore

40 days

D. STREET ADDRESS (If rural, give location)

ST. Cecilia's RECTORY, WINDSOR AVE

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

S

Yrs.  
Mos.  
Days

8. DATE OF BIRTH

11-18-87

9. AGE (In years  
last birthday)

62

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

CLERGYMAN

10B. KIND OF BUSINESS OR  
INDUSTRY

CHURCH

11. BIRTHPLACE (State or foreign country)

MARYLAND.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

14. MOTHER'S MAIDEN NAME

Mary Mann

17. INFORMANT

ADDRESS

Mrs. Winifred. Pheasant Liberty Hotel

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) GASTRO-INTestinal Hemorrhage 14 hrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B) CARCINOMA of STOMACH

5 yrs

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

May 1946

19B. MAJOR FINDINGS OF OPERATION

CARCINOMA OF STOMACH

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

m.

WHILE AT

NOT WHILE

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-19, 1950 to 6-24, 1950, that I last saw the  
deceased alive on 6-24, 1950, and that death occurred at 5:15 P.m., from the causes and on the date stated above.

23A. SIGNATURE

George D. Solomon Jr.

M. D.

23B. ADDRESS

Bon Secours Hosp.

23C. DATE SIGNED

6-24-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

6/28/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Cem.

24D. LOCATION (City, town, or county)

4300 Old Frederick Rd.

(State)

DATE RECEIVED BY  
LOCAL REGISTRY

JUN 26 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

John J. Brown &amp; Son

ADDRESS

46B St.



STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL  
OFFICE OF THE CLERK OF THE SUPREME COURT  
OFFICE OF THE CLERK OF THE COUNTY COURT  
OFFICE OF THE CLERK OF THE DISTRICT COURT  
OFFICE OF THE CLERK OF THE JUDICIAL DEPARTMENT  
OFFICE OF THE CLERK OF THE LEGISLATIVE DEPARTMENT  
OFFICE OF THE CLERK OF THE EXECUTIVE DEPARTMENT  
OFFICE OF THE CLERK OF THE JUDICIAL DEPARTMENT  
OFFICE OF THE CLERK OF THE LEGISLATIVE DEPARTMENT  
OFFICE OF THE CLERK OF THE EXECUTIVE DEPARTMENT

IN SENATE,  
JANUARY 1, 1908.

REPORT OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1907.

ALBANY:

THE UNIVERSITY OF THE STATE OF NEW YORK,

1908.

PRINTED BY THE UNIVERSITY OF THE STATE OF NEW YORK,

ALBANY.

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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5637  
Registered No. \_\_\_\_\_

|   |                               |  |  |
|---|-------------------------------|--|--|
| BIRTH NO. <u>5637</u>   |                               | 2. DATE OF DEATH <u>June 25, 1950</u>  |  |
| 1. NAME OF DECEASED (Type or Print) <u>THOMAS D. GOLDBERG</u>   |                               |  |  |
| 3. PLACE OF DEATH:<br>A. <u>Baltimore City, Maryland</u>  |                               | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>Maryland</u><br>B. COUNTY _____ |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><u>Sinai Hospital</u> |                               | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><u>Baltimore</u> <u>15-05</u>                        |  |
| C. Length of stay in Baltimore <u>66 Yrs</u><br>Yrs. _____ Mos. _____ Days _____  |                               | D. STREET ADDRESS (If rural, give location)<br><u>2611 Liberty Heights Avenue</u>  |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Married</u>  | 8. DATE OF BIRTH <u>May 7, 1883</u>  |
|   |                               |  | 9. AGE (In years last birthday) <u>67</u><br>If Under 1 Year: Months _____ Days _____<br>If Under 24 Hours: Hours _____ Min. _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)<br><u>Moving Picture Business</u>          |                               | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Owner</u>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |                               | 12. CITIZEN OF WHAT COUNTRY?<br>_____  |  |
| 13. FATHER'S NAME<br><u>Meyer Goldberg</u>  |                               | 14. MOTHER'S MAIDEN NAME<br><u>Minnie Gochrah</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                              |                               | 16. SOCIAL SECURITY NO. _____  |  |
| 17. INFORMANT<br><u>Mrs Esther B Goldberg</u>   |                               | ADDRESS <u>2611 Liberty Heights Ave</u>  |  |

|   |  |  |
|---|--|--|
| 18. <u>E 978.7</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><u>Crushing injuries of chest</u><br>DUE TO _____<br>(A) _____<br>(B) _____<br>(C) _____ |  | INTERVAL BETWEEN ONSET AND DEATH.<br>_____<br>_____<br>_____ |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO _____<br>(B) _____<br>(C) _____  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>_____<br>_____<br>_____  |  |  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 19A. DATE OF OPERATION <u>June 25, 1950</u>   |  | 19B. MAJOR FINDINGS OF OPERATION _____  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                     |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br><u>Hospital</u>  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><u>Monument Street &amp; Rutland Avenue</u> |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY<br><u>June 25, 1950 10:45 P.m.</u>  |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?<br><u>Jumped from 5th story window</u>   |  |
| 22. I certify that I took charge of the remains described above, held an <u>Insp. &amp; Inquiry</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input checked="" type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |  |   |  |   |  |
| 23A. SIGNATURE<br><u>RS Fisher</u>  |  | 23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/><br>M.D. _____ |  | 23C. DATE SIGNED<br><u>6-26-50</u>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 24B. DATE<br><u>June 28, 1950</u>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Mt Nebo Cemetery New York City</u>   |  |
| 24D. LOCATION (City, town, or county)<br><u>New York City</u>   |  | 24E. REGISTRAR'S SIGNATURE<br><u>Huntington Williams, M.D.</u>  |  | 25. FUNERAL DIRECTOR<br><u>Sol Lewinson + Bros North ave</u>  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><u>JUN 26 1950</u>  |  | V S 151   |  | ADDRESS <u>1126 W 164 E</u>   |  |

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

DEATH OF

NAME OF DECEASED  
AGE  
SEX  
RACE  
RELATIONSHIP TO DECEASED

DATE OF DEATH

PLACE OF DEATH  
CITY  
COUNTY  
STATE

CAUSE OF DEATH  
DISEASE  
MANNER OF DEATH

NAME OF PHYSICIAN

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF BURIAL PLACE

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF REGISTRAR

325  
5638BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5638

BIRTH NO.

|   |                                  |   |   |  |  |
|---|----------------------------------|---|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>GEORGE B. DODSON</b>  |                                  |   | 2. DATE OF DEATH <b>6-24-1950</b>   |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION <b>330 S. Patterson Park Avenue</b> |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>1-05</b>                |  |  |
| C. Length of stay in Baltimore <b>Life</b>  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>330 S. Patterson Park Avenue</b>  |  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b> | 8. DATE OF BIRTH  | 9. AGE (In years last birthday)<br><b>87</b> | If Under 1 Year Months: Days If Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Watchman</b>                                      |                                  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>   |  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                                  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |
| 13. FATHER'S NAME<br><b>George Dodson</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b> <b>None</b>                   |                                  |   | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   |  |  |
| 17. INFORMANT<br><b>Alma Dodson (daughter)</b>  |                                  |   | ADDRESS<br><b>2103 E. Fayette St.</b>   |  |  |

|  |                                  |
|--|----------------------------------|
| 18. <b>794X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Senility</b><br>DUE TO (A) .....<br>ANTECEDENT CAUSES<br>(B) .....<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(C) .....<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | INTERVAL BETWEEN ONSET AND DEATH |
|--|----------------------------------|

|  |   |  |  |  |
|--|---|--|--|--|
| 19A. DATE OF OPERATION <b>0</b>  |   | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |  |
| 22. I hereby certify that I attended the deceased from <b>Jan</b> , 19 <b>48</b> , to <b>June 24</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>Apr. 30</b> , 19 <b>50</b> , and that death occurred at <b>1.30 p. m.</b> , from the causes and on the date stated above. |   |  |  |  |
| 23A. SIGNATURE<br><b>Sigmund R. Nowak</b>  |   | 23B. ADDRESS<br><b>408 S. Patterson Ph. An.</b>                          |  | 23C. DATE SIGNED<br><b>June 26, 1950</b>                                 |

|  |   |   |  |
|--|---|---|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24B. DATE<br><b>6-27-1950</b>                             | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>    | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore County, Maryland</b> |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 26 1950</b>     | REGISTRAR'S SIGNATURE<br><b>Wilmington Williams, M.D.</b> | 25. FUNERAL DIRECTOR<br><b>Lilly &amp; Zeiler Inc. Balto. Md.</b> |  |

VS 150

162 B

Dr. Novak  
P.P. Ave.

1950  
18  
E91

652  
50 5639

50 5639

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Mary Kerns

2. DATE  
OF  
DEATH

June 24/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Home for the Aged

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years,  
last birthday)If Under 1 Year  
Months Days  
If Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
Yes, no or unknown (If yes, give war and dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Chronic Myocarditis

5 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Arterio Sclerosis

10 yrs

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

22. I hereby certify that I attended the deceased from Jan 10, 1950, to June 24, 1950, that I last saw the deceased alive on June 24, 1950, and that death occurred at 12:15 PM, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

E. G. Hall

M. D.

1631 E North Ave

6/26-1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

June 27/50

Cathedral

Baltimore Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

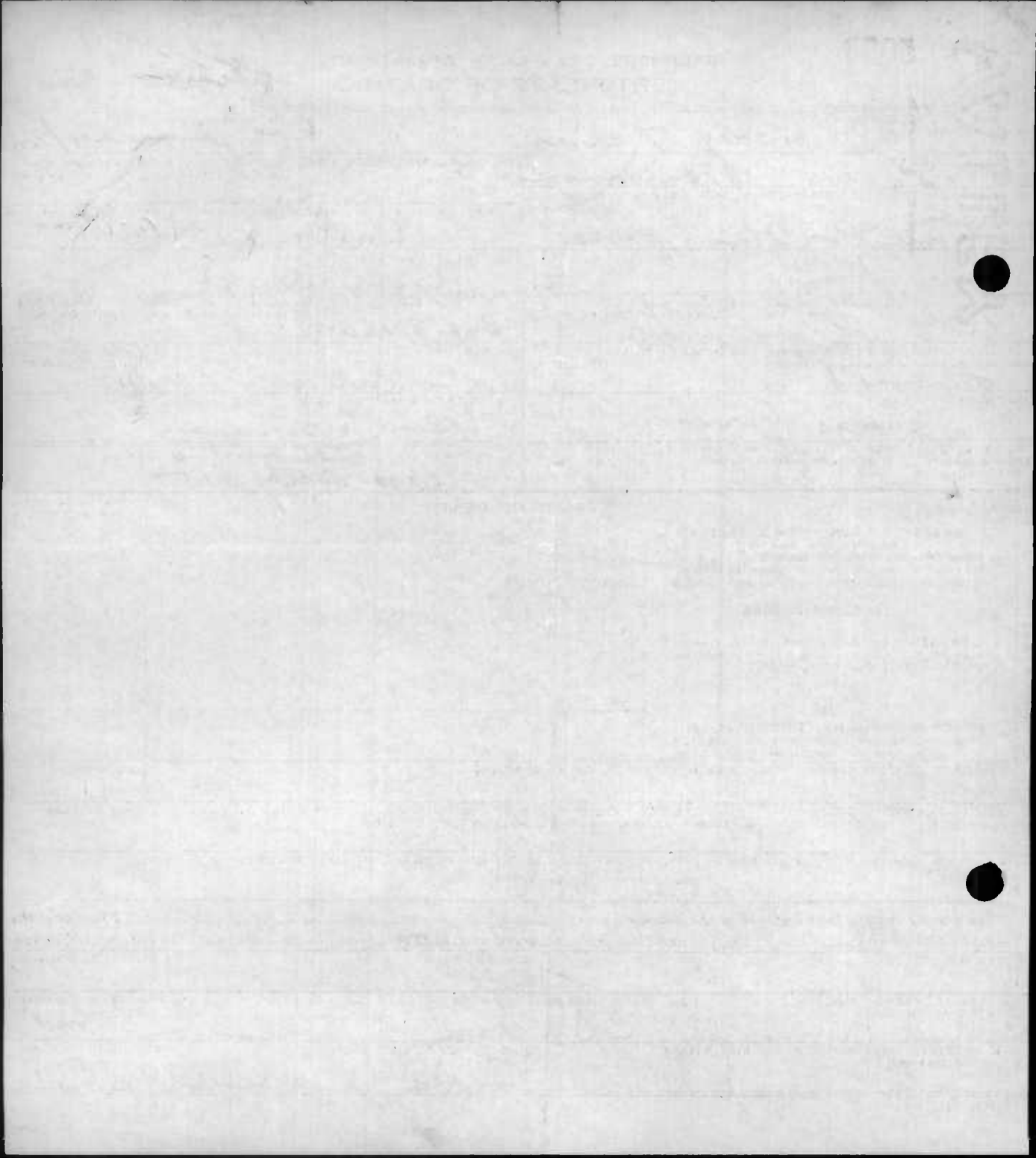
Huntington Williams

Reta Wiedefeld 906 E. Biddle St

JUN 26 1950

937





452  
5640BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5640

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>George M. Blankner</i>  |                                  | 2. DATE OF DEATH <i>June 22-1950</i>  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>3130 Wilken Ave</i>  |                                  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION   |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 20-06</i>                      |  |
| c. Length of stay in Baltimore <i>58 yrs.</i>   |                                  | D. STREET ADDRESS (If rural, give location)<br><i>3130 Wilken Ave</i>   |  |
| 5. SEX<br><i>Male</i>   | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Married</i>   | 8. DATE OF BIRTH<br><i>Jan 7-1892</i>        |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Paper Hauler</i>  |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Newspaper</i>   | 9. AGE (In years last birthday)<br><i>58</i> |
| 11. BIRTHPLACE (State or foreign country)<br><i>Bald. Ind.</i>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>   |  |
| 13. FATHER'S NAME<br><i>Beauregard Blankner</i>   |                                  | 14. MOTHER'S MAIDEN NAME<br><i>Annie Brushweller</i>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><i>No</i>  |                                  | 16. SOCIAL SECURITY NO.<br><i>218-03-2559</i>   |  |
| 17. INFORMANT<br><i>Mrs. Mary Blankner</i>  |                                  | ADDRESS<br><i>3130 Wilken Ave</i>   |  |
| 18. CAUSE OF DEATH<br><i>420.1</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Crown insufficiency</i><br>DUE TO<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><i>none</i><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><i>none</i><br>INTERVAL BETWEEN ONSET AND DEATH<br><i>2 yrs</i> |                                  |   |  |
| 19A. DATE OF OPERATION<br><i>none</i>   |                                  | 19B. MAJOR FINDINGS OF OPERATION  |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                    |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                                  |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br><i>INJURY</i>  |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                   |  |
| 21F. HOW DID INJURY OCCUR?  |                                  |   |  |
| 22. I hereby certify that I attended the deceased from <i>2/1</i> , 19 <i>49</i> , to <i>6/22</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>6/1</i> , 19 <i>50</i> , and that death occurred at <i>5:10</i> m., from the causes and on the date stated above.   |                                  |   |  |
| 23A. SIGNATURE<br><i>Benjamin Miller MD</i>   |                                  | 23B. ADDRESS<br><i>2130 Wilken Ave</i>  |  |
| 23C. DATE SIGNED<br><i>6/22/50</i>  |                                  |   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |                                  | 24B. DATE<br><i>6/26/50</i>   |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br><i>Loudon Park</i>  |                                  | 24D. LOCATION (City, town, or county) (State)<br><i>Balto Ind</i>   |  |
| 25. FUNERAL DIRECTOR<br><i>Wm. T. Beyer Jr</i>  |                                  | ADDRESS<br><i>1512 Hollins St</i>   |  |

IN SENATE,  
January 10, 1907.  
REPORT  
OF THE  
ATTORNEY GENERAL,  
JAMES C. CLARK,  
IN RESPONSE TO A  
RESOLUTION PASSED  
BY THE SENATE  
MAY 1, 1906.

*James C. Clark*

ALBANY:  
J.B. LIPPINCOTT & CO.,  
PRINTERS,  
1907.

600

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5641

Registered No.

|  |                           |  |                                    |  |  |
|--|---------------------------|--|------------------------------------|--|--|
| BIRTH NO. 5641   |                           | 1. NAME OF DECEASED<br>(Type or Print) <b>Mr. WILLIAM LEWIS HARRY</b>  |                                    | 2. DATE OF DEATH <b>6/24/50.</b>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                           | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY |                                    |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Church Home &amp; Hospital</b>  |                           | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 26-09</b>                    |                                    |  |  |
| C. Length of stay in Baltimore <b>30</b>   |                           | D. STREET ADDRESS (If rural, give location) <b>3813 Foster Ave</b>   |                                    |  |  |
| 5. SEX <b>M</b>  | 6. COLOR OR RACE <b>N</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>M</b>   | 8. DATE OF BIRTH <b>Apr 7/1896</b> | 9. AGE (In years last birthday) <b>54</b>  | 10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                           | 10B. KIND OF BUSINESS OR INDUSTRY <b>Land Packer</b>   |                                    | 11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>                    |  |
| 13. FATHER'S NAME <b>Harry James</b>   |                           | 14. MOTHER'S MARRIEN NAME <b>Mary Walton</b>   |                                    | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>YES</b>  |                           | 16. SOCIAL SECURITY NO. <b>WORLDWARI 213-05-2516</b>   |                                    | 17. INFORMANT ADDRESS <b>Mrs. William Harry Same</b>                             |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   |                           | CAUSE OF DEATH   |                                    | INTERVAL BETWEEN ONSET AND DEATH   |  |
| DUE TO (A) <b>Myocardial Infarction</b>  |                           |  |                                    | <b>2 days</b>  |  |
| DUE TO (B) <b>Pulmonary Infarction</b>   |                           |  |                                    | <b>1 day</b>   |  |
| DUE TO (C) <b>Pleural Effusion</b>   |                           |  |                                    |  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |                           |  |                                    |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                           |  |                                    |  |  |
| 19A. DATE OF OPERATION <b>7</b>  |                           | 19B. MAJOR FINDINGS OF OPERATION   |                                    | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |                           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                               |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)         |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   |                           | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                 |                                    | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <b>6/19/50</b> , to <b>6/24/50</b> , that I last saw the deceased alive on <b>6/24/50</b> , and that death occurred at <b>6:30 A.M.</b> , from the causes and on the date stated above. |                           |  |                                    |  |  |
| 23A. SIGNATURE <b>Robert E. Enzor</b>  |                           | 23B. ADDRESS <b>Church Home &amp; Hosp</b>   |                                    | 23C. DATE SIGNED <b>6/24/50</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  |                           | 24B. DATE <b>JUNE 27 1950</b>  |                                    | 24C. NAME OF CEMETERY OR CREMATORY <b>HOLY REDELMER CEM</b>                      |  |
| 24D. LOCATION (City, town, or county) <b>BELAIR RD.</b>  |                           | 24E. DATE RECEIVED BY LOCAL REGISTRAR <b>JUN 26 1950</b>   |                                    | 24F. REGISTRAR'S SIGNATURE <b>Wm. H. Williams</b>                                |  |
| 24G. FUNERAL DIRECTOR <b>Charles S. Zeiler</b>   |                           | 24H. ADDRESS <b>901 S. Conkling St.</b>  |                                    | 24I. 496 X 5   |  |
| 24J. 94a   |                           |  |                                    |  |  |

CERTIFICATE OF DEATH

1940

John Doe

Age 50

Married

Residence

Occupation

Cause of Death

Place of Death

Time of Death

Signature

253  
50 5642BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5642

|   |                     |  |   |
|---|---------------------|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) Thomas Leo Nugent  |                     | 2. DATE OF DEATH June 24, 1950   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                     | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE Md.<br>B. COUNTY |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTE US MARINE HOSPITAL<br>WYMAN PARK DRIVE & 31st St.   |                     | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 2-03                     |   |
| C. Length of stay in Baltimore Lifetime Yrs. Mos. Days  |                     | D. STREET ADDRESS (If rural, give location)<br>1631 Thames St., Balto., Md.  |   |
| 5. SEX m  | 6. COLOR OR RACE wh | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) divorced   | 8. DATE OF BIRTH Feb. 16, 1891                        |
| 10A. USUAL OCCUPATION (Give kind of work done during most of worklog life, even if retired) Capt.   |                     | 10B. KIND OF BUSINESS OR INDUSTRY Seafarer   |   |
| 13. FATHER'S NAME Thomas Nugent,  |                     | 14. MOTHER'S MAIDEN NAME Nora Winks  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes WWI   |                     | 16. SOCIAL SECURITY NO. ?  |   |
| 17. INFORMANT   |                     | ADDRESS Records - US Marine Hospital, Balto., Md.  |   |
| 18. 416 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>Rheumatic heart disease<br>DUE TO (A)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>Nephritis, embolic<br>DUE TO (B)<br>OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>(C)<br>II |                     |  | INTERVAL BETWEEN ONSET AND DEATH<br>Unknown<br>6 mos. |
| 19A. DATE OF OPERATION 0  |                     | 19B. MAJOR FINDINGS OF OPERATION   |   |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                     |  |   |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                     | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                          |   |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                     |  |   |
| 21D. TIME (Month) (Day) (Year) (Hour) 0 INJURY  |                     | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>             |   |
| 21F. HOW DID INJURY OCCUR?  |                     |  |   |
| 22. I hereby certify that I attended the deceased from May 13, 1950 to June 24, 1950 that I last saw the deceased alive on June 24, 1950 and that death occurred at 7:45 A.M., from the causes and on the date stated above.  |                     |  |   |
| 23A. SIGNATURE William Roomnich<br>william Roomnich, Surgeon  |                     | 23B. ADDRESS U.S. MARINE HOSPITAL, BALTO., MD.<br>M. D.  |   |
| 23C. DATE SIGNED 6/26/50  |                     |  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   |                     | 24B. DATE  |   |
| BURIAL JUNE 27, 1950 PARKWOOD   |                     | TAYLOR AVE   |   |
| 24C. NAME OF CEMETERY OR CREMATORY  |                     | 24D. LOCATION (City, town, or county) (State)  |   |
| DATE RECEIVED BY LOCAL REGISTRAR JUN 26 1950  |                     | REGISTRAR'S SIGNATURE  |   |
| 25. FUNERAL DIRECTOR  |                     | ADDRESS  |   |
| VS 150  |                     | 130 57   |   |
|   |                     | 95B 2  |   |



DEATH CERTIFICATE

10-1-1918

10-1-1918

Attest: J. H. BARNES

THOMAS A. BUE

10-1-1918

655  
50 5643BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5643  
Registered No.

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>HARRY HERMAN</b>  |                                  | 2. DATE OF DEATH<br><b>June 25, 1950</b>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>(home) <b>855 N. Eutaw Street</b>   |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>                               |  |
| C. Length of stay in Baltimore<br><b>73 years</b>  |                                  | D. STREET ADDRESS (If rural, give location)<br><b>855 N. Eutaw Street</b>  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>  | 8. DATE OF BIRTH<br><b>March 27, 1866</b>    |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>retired</b>  |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Ice</b>  | 9. AGE (In years last birthday)<br><b>84</b> |
| 13. FATHER'S NAME<br><b>Henry Herman</b>   |                                  | 11. BIRTHPLACE (State or foreign country)<br><b>Philadelphia, Penna.</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>NO</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 16. SOCIAL SECURITY NO.<br><b>NONE</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Anna Heim</b>   |  |
| 17. INFORMANT<br><b>Messrs. Herman (sons)</b>  |                                  | ADDRESS<br><b>855 N. Eutaw St.</b>   |  |
| 18. <b>610 X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>myocardial degeneration</b><br>DUE TO<br><b>Prostatitis</b><br>DUE TO<br><b>Diabetes mellitis</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                                  |  |  |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs.</b><br><b>11 yrs.</b>   |                                  |  |  |
| 19A. DATE OF OPERATION<br><b>6/12/50</b>   |                                  | 19B. MAJOR FINDINGS OF OPERATION<br><b>Hypertrophy of Prostate</b>   |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |  |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                                      |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                                  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>INJURY  |                                  | 21E. INJURY OCCURRED<br>WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>                      |  |
| 21F. HOW DID INJURY OCCUR?   |                                  |  |  |
| 22. I hereby certify that I attended the deceased from <b>June 1937</b> to <b>6/25</b> , 1950, that I last saw the deceased alive on <b>6/26</b> , 1950, and that death occurred at <b>7P</b> m., from the causes and on the date stated above.  |                                  |  |  |
| 23A. SIGNATURE<br><b>Kenneth B. Boyd</b><br>M. D.  |                                  | 23B. ADDRESS<br><b>1114 St. Paul St</b>  |  |
| 23C. DATE SIGNED<br><b>6/26/50</b>   |                                  |  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 24B. DATE<br><b>June 28, 1950</b>  |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b>   |                                  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore City Md.</b>   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 26 1950</b>   |                                  | REGISTRAR'S SIGNATURE<br><b>Wilmington Williams, Jr.</b>   |  |
| 25. FUNERAL DIRECTOR<br><b>STEWART &amp; MOVEN</b>   |                                  | ADDRESS<br><b>* 108 W. North Ave. - City</b>   |  |

CERTIFICATE OF DEATH

1920

1920



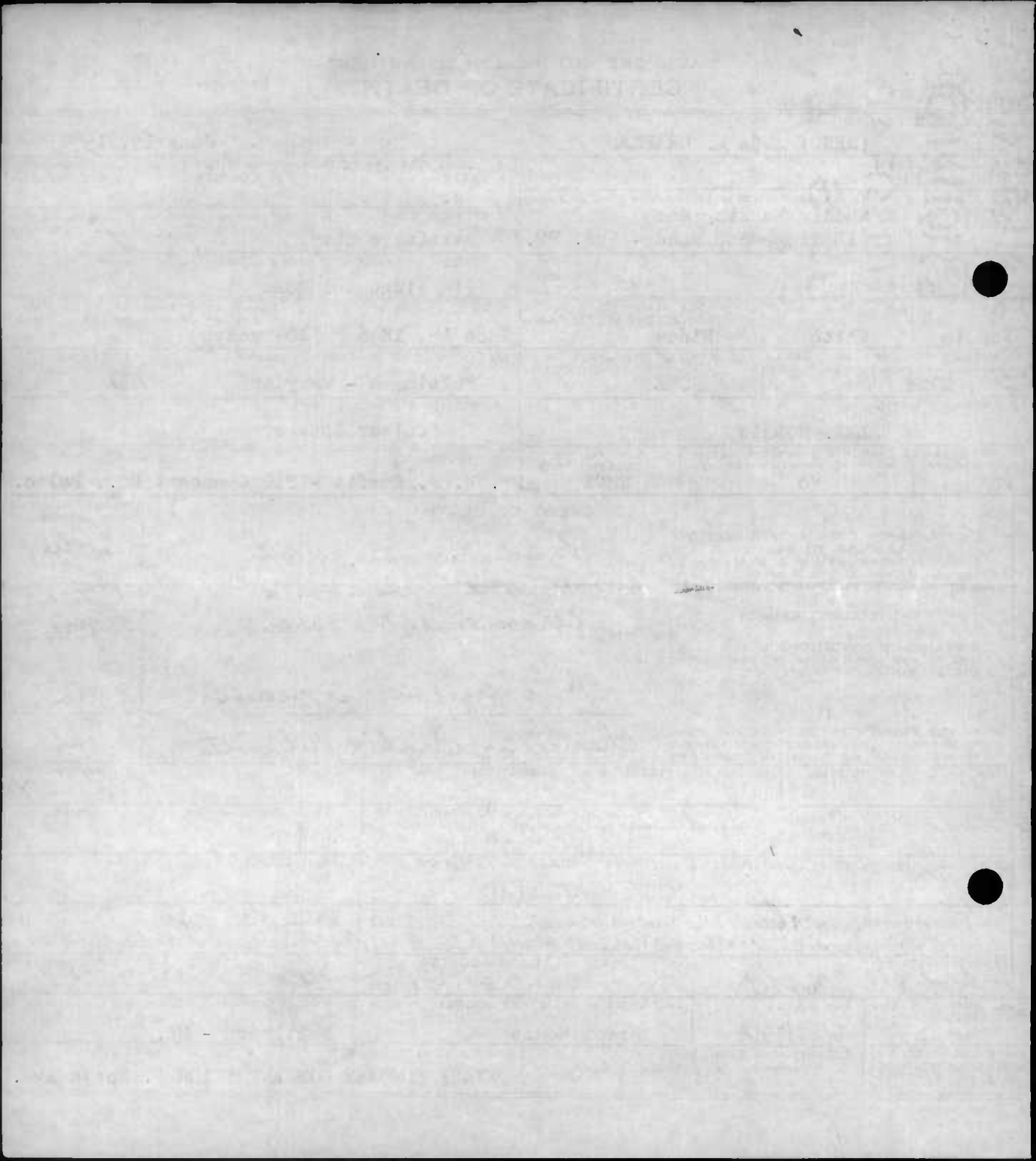
**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 5644

155  
5644

|   |                                  |  |  |   |   |
|---|----------------------------------|--|--|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>(MRS.) ANNA M. CHAPMAN</b>  |                                  |  |  | 2. DATE OF DEATH<br><b>June 25, 1950</b>  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |  |  | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <b>Md.</b><br>B. COUNTY <b>Baltimore City</b> |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Gaddis Nursing Home</b><br><b>213 Ridgewood Road - Rol. Pk.</b>   |                                  |  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>27-14</b>  |   |
| c. Month of stay in Baltimore<br>Yrs.<br>Mos.<br>Days   |                                  |  |  | D. STREET ADDRESS (If rural, give location)<br><b>213 Ridgewood Road</b>  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widow</b>  | 8. DATE OF BIRTH<br><b>June 15, 1846</b> |   | 9. AGE (In years last birthday)<br><b>104 years</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>NONE</b>  |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>NONE</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore - Maryland</b>  |   |
| 13. FATHER'S NAME<br><b>ALEX. NORRIS</b>  |                                  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>NO</b>  |                                  |  |  | 16. SOCIAL SECURITY NO.<br><b>NONE</b>  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Louiser Spencer</b>  |                                  |  |  | 17. INFORMANT ADDRESS<br><b>Mr. M. P. Morfit - 212 Chancery Rd., Balto.</b>   |   |
| 18. <b>332X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Branchopneumonia, acute</b><br>DUE TO <b>cerebral thrombosis</b><br><b>Cerebral arteriosclerosis</b><br>DUE TO <b>Generalized arteriosclerosis</b><br><b>Chronic hypertrophic arthritis</b> |                                  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hr.</b><br><b>1 yr.</b><br><b>5 yrs.</b><br><b>? yr.</b><br><b>? yr.</b>                              |   |
| 19A. DATE OF OPERATION<br><b>6/27/1950</b>  |                                  |  |  | 19B. MAJOR FINDINGS OF OPERATION  |   |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |                                  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I hereby certify that I attended the deceased from <u>1940</u> , to <u>June 25</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>June 24</u> , 19 <u>50</u> , and that death occurred at <u>10 A. m.</u> , from the causes and on the date stated above.  |                                  |  |  |   |   |
| 23A. SIGNATURE<br><i>Robert H. Stewart</i>  |                                  | 23B. ADDRESS<br>M. D. <i>Max Morfit Bldg.</i>  |  | 23C. DATE SIGNED<br><b>6/26/50</b>  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 24B. DATE<br><b>6/27/1950</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b>  |   |
| 24D. LOCATION (City, town, or county)<br><b>Baltimore - Md.</b>   |                                  | 24E. STATE<br><b>Baltimore - Md.</b>   |  |   |   |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 26 1950</b>  |                                  | REGISTRAR'S SIGNATURE<br><i>Wm. J. Williams</i>  |  | 25. FUNERAL DIRECTOR ADDRESS<br><b>STEWART &amp; MOWEN COMPANY * 108 W. North Ave.</b>  |   |

MEDICAL CERTIFICATION



324  
5845  
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5645  
Registered No.

|  |                          |   |   |
|--|--------------------------|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) RANDOLPH MITCHELL   |                          | 2. DATE OF DEATH June 23, 1950  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                          | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland<br>B. COUNTY |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION South Baltimore Gen. Hosp. |                          | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 23-01                         |   |
| C. Length of stay in Baltimore<br>Yrs. Mos. Days   |                          | D. STREET ADDRESS (If rural, give location)<br>1015 Leadenhall Street   |   |
| 5. SEX Male  | 6. COLOR OR RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married (Sep)   | 8. DATE OF BIRTH June 25, 1908 47                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer  |                          | 10B. KIND OF BUSINESS OR INDUSTRY Construction  | 11. BIRTHPLACE (State or foreign country) Mobile Ala. |
| 13. FATHER'S NAME Henry Mitchell   |                          | 14. MOTHER'S MAIDEN NAME Julia Rivers   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No  |                          | 16. SOCIAL SECURITY NO.   | 17. INFORMANT Chad Bennett                            |
|  |                          | ADDRESS   |   |

|   |  |  |  |
|---|--|--|--|
| 18. 443 X<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>Hypertensive cardiovascular disease<br>DUE TO<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  | CAUSE OF DEATH<br>INTERVAL BETWEEN ONSET AND DEATH |  |
|---|--|--|--|

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 19A. DATE OF OPERATION   |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |  |  |  |   |  |
| 23A. SIGNATURE Stanley G. Durlacher M.D.   |  | 23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> |  | 23C. DATE SIGNED 6-23-50  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial   |  | 24B. DATE 6-29-1950  |  | 24C. NAME OF CEMETERY OR CREMATORY Mt. Laurel Cmn. Philadelphia Pa.                 |  |
| 24D. LOCATION (City, town, or county) (State)  |  | 25. FUNERAL DIRECTOR Mrs. Kate R. Williams   |  | ADDRESS 322 N Schroeder St  |  |
| DATE RECEIVED BY LOCAL REGISTRAR JUN 26 1950   |  | REGISTRAR'S SIGNATURE  |  |   |  |

98849

93D



STATE OF NEW YORK  
CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

235  
50 5646  
BIRTH NO. 5646BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5646  
Registered No.

|   |  |  |  |
|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Roberta Boston</b>  |  | 2. DATE OF DEATH <b>June 20 50</b>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |  | 4. USUAL RESIDENCE (Where deceased lived before admission)<br>A. STATE <b>Ind</b> B. COUNTY <b>Ind</b>   |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>JOHNS HOPKINS HOSPITAL</b>  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore - 16-02</b> |  |
| D. STREET ADDRESS (If rural, give location)<br><b>644 E. Carey St.</b>  |  | E. DATE OF BIRTH <b>9-9-20</b>   |  |
| F. SEX <b>Female</b>  |  | G. AGE (In years last birthday) <b>29</b>  |  |
| H. COLOR OR RACE <b>Negro</b>   |  | I. Under 1 Year Months: Days Hours: Min.   |  |
| J. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>  |  | K. Under 24 Hours Hours: Min.  |  |
| L. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Machinery Operator Rubber Wheel Factory</b> |  | M. BIRTHPLACE (State or foreign country)<br><b>A.A. Co. Md.</b>  |  |
| N. KIND OF BUSINESS OR INDUSTRY   |  | O. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| P. FATHER'S NAME<br><b>Benjamin Oden</b>  |  | Q. MOTHER'S MAIDEN NAME<br><b>Rachel Benson</b>  |  |
| R. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)<br><b>No</b>  |  | S. SOCIAL SECURITY NO.   |  |
| T. INFORMANT<br><b>JOHNS HOPKINS HOSPITAL</b>   |  | U. ADDRESS   |  |

|  |  |
|--|--|
| 18. <b>296X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Thrombocytopenic purpura</b><br>DUE TO<br>(A) <b>Thrombocytopenic purpura</b><br>(B)<br>DUE TO<br>(C)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>26 wks</b> |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B)<br>DUE TO<br>(C)<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 19A. DATE OF OPERATION <b>6-29-1960</b>   |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>June 20, 1960</b> to <b>June 25, 1960</b> that I last saw the deceased alive on <b>June 24, 1960</b> and that death occurred at <b>12:30 p.m.</b> , from the causes and on the date stated above. |  |  |  |   |  |
| 23A. SIGNATURE<br><b>William W. Wintermuth, D.</b>  |  | 23B. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>  |  | 23C. DATE SIGNED<br><b>6/25/50</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>6-29-1960</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cem.</b>                       |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Cedar Hill Md.</b>  |  | 24E. FUNERAL DIRECTOR<br><b>Huntington Williams</b>  |  | 24F. ADDRESS<br><b>322 N Schroeder St</b>   |  |

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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 5647

|  |                                    |   |   |
|--|------------------------------------|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>PEARL MOYE</b>   |                                    | 2. DATE OF DEATH <b>June 23, 1950</b>   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>18-01</b> |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>University Hospital</b> |                                    | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>  |   |
| D. DATE OF DEATH IN BALTIMORE<br>Yrs. <b>18-01</b><br>Mos. <b>18-01</b><br>Days <b>18-01</b>                       |                                    | E. STREET ADDRESS (If rural, give location)<br><b>416 N. Fremont Avenue</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>Colored</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>   | 8. DATE OF BIRTH<br><b>May 1, 1914</b>                |
| 9. AGE (In years last birthday)<br><b>36</b>   |                                    | 10. UNDER 1 Year<br>Months: <b>18</b> Days: <b>01</b>   | 11. UNDER 24 Hours<br>Hours: <b>18</b> Min: <b>01</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>    |                                    | 10B. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. FATHER'S NAME<br><b>Milton Jones</b>   |                                    | 12. MOTHER'S MAIDEN NAME<br><b>Fannie ?</b>   |   |
| 13. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>No.</b>                  |                                    | 14. SOCIAL SECURITY NO.   |   |
| 15. INFORMANT<br><b>John Moye</b>  |                                    | ADDRESS <b>404 E-22 1/2 St.</b>   |   |

|   |  |                                  |
|---|--|----------------------------------|
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>580X</b><br><b>Degeneration of liver, subacute - parenchymatous</b> |  | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B) _____<br>(C) _____  |  |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>_____  |  |                                  |

|   |   |   |  |   |
|---|---|---|--|---|
| 19A. DATE OF OPERATION  |   | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                              |  |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |  |   |
| 22. I certify that I took charge of the remains described above, held an <u>Autopsy</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |   |   |  |   |
| 23A. SIGNATURE<br><i>[Signature]</i>  |   | 23B. CHIEF MEDICAL EXAMINER.....<br>ASSISTANT MEDICAL EXAMINER.....<br>M.D. MEDICAL INVESTIGATOR..... |  | 23C. DATE SIGNED<br><b>June 24, 1950</b>  |

|  |                               |   |  |
|--|-------------------------------|---|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24B. DATE<br><b>6-26-1950</b> | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Wt. Auburn Cem</b> | 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b>                         |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 26 1950</b>     |                               | REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                 | 25. FUNERAL DIRECTOR<br><b>Mrs. Katie R. Williams</b><br>ADDRESS <b>322 N Schroeder St</b> |

MASSACHUSETTS DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH. IT IS TO BE SIGNED BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH, AND BY THE REGISTRAR OF VITALS, AND BY THE CLERK OF THE BOARD OF HEALTH.

THE REGISTRAR OF VITALS SHALL SIGN THIS CERTIFICATE OF DEATH, AND SHALL FORWARD IT TO THE CLERK OF THE BOARD OF HEALTH, WHO SHALL FORWARD IT TO THE DEPARTMENT OF HEALTH.

| Med. Exams. Case<br>5648 to Hosp.   |  | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH  |  | Registered No. 50-5648  |  |
|---|--|---|--|---|--|
| BIRTH NO.   |  | 1. NAME OF DECEASED<br>(Type or Print) <u>Eleanor Lewis</u>   |  | 2. DATE OF DEATH <u>June 23, 1950</u>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <u>Ship. Tunnel Cl</u>  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>MD</u><br>B. COUNTY <u>8</u> |  |   |  |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><u>JOHNS HOPKINS HOSPITAL</u>  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><u>Baltimore 20-01</u>                            |  |   |  |
| 6. D. STREET ADDRESS (If rural, give location)<br><u>1907 Lauretta ave</u>  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Married</u>   |  |   |  |
| 8. DATE OF BIRTH <u>3-3-1900</u>  |  | 9. AGE (In years last birthday) <u>50</u>   |  | 10. Under 1 Year Months: Days: Hours: Min.  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Balto Md.</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |   |  |
| 13. FATHER'S NAME<br><u>Samuel Wright</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Eleanora Brown</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><u>No</u>  |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS<br><u>JOHNS HOPKINS HOSPITAL</u>                              |  |
| 18. <u>170X</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  | CAUSE OF DEATH<br>(A) <u>Metastatic Carcinoma</u><br>DUE TO <u>Carcinoma of Breast</u><br>(B) _____<br>DUE TO _____<br>(C) _____  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19A. DATE OF OPERATION<br><u>7-6-46</u>   |  | 19B. MAJOR FINDINGS OF OPERATION<br><u>Adenocarcinoma of Breast</u>   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                            |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <u>6-23-</u> , 19 <u>50</u> to <u>6-23-</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>6-23-</u> , 19 <u>50</u> , and that death occurred at <u>11:25</u> m., from the causes and on the date stated above.   |  |   |  |   |  |
| 23A. SIGNATURE<br><u>Walter Lawrence</u><br>M. D.   |  | 23B. ADDRESS<br><u>JOHNS HOPKINS HOSPITAL</u>   |  | 23C. DATE SIGNED<br><u>6-23-50</u>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 24B. DATE<br><u>6-27-1950</u>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Auburn Cem.</u>                        |  |
| 24D. LOCATION (City, town, or county) (State)<br><u>Balto. Md.</u>  |  | 25. FUNERAL DIRECTOR<br><u>Wm. J. Williams</u>  |  | ADDRESS<br><u>322 N Schroeder St</u>  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><u>JUN 26 1950</u><br>VS 150<br>Approved by Med. Exam.  |  |   |  |   |  |



NOT A MEDICAL EXAMINER'S CASE

*R. Fisher*

M.D.

CHIEF OR ASST. MEDICAL EXAMINER

320

5649

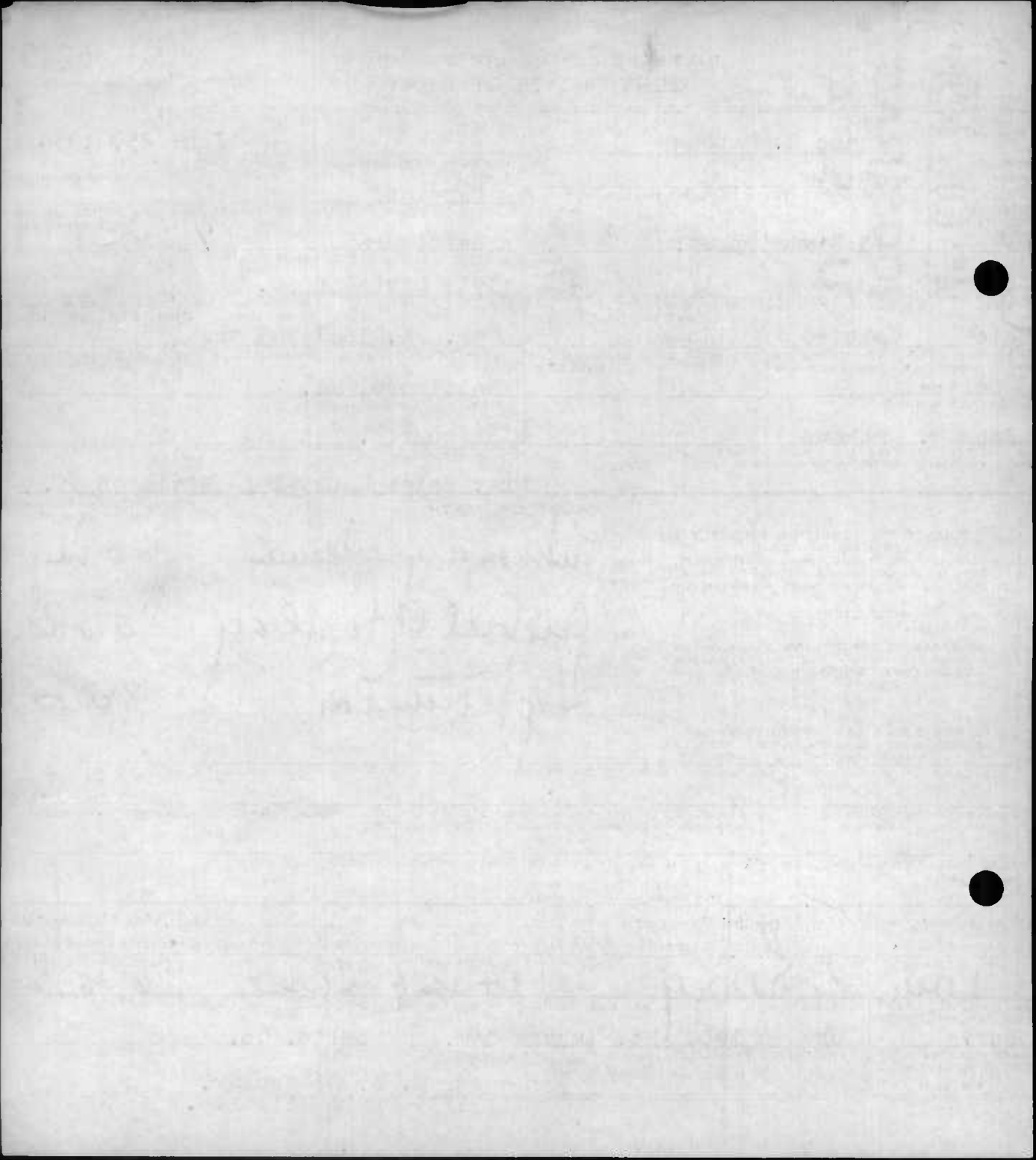
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5649

Registered No.

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Isaac S. Mathews</b>   |                                  | 2. DATE OF DEATH <b>June 25, 1950</b>   |  |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>Baltimore</b> |  |
| 5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br><b>1913 Division St.</b>  |                                  | 6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>  |  |
| 7. Length of stay in Baltimore <b>Life</b>   |                                  | 8. STREET ADDRESS (If rural, give location)<br><b>1913 Division St.</b>   |  |
| 9. SEX <b>Male</b>   | 10. COLOR OR RACE <b>Colored</b> | 11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b>  | 12. DATE OF BIRTH <b>Mar. 14, 1867</b> |
| 13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>   |                                  | 14. AGE (In years last birthday) <b>83 yrs</b>  |  |
| 15. FATHER'S NAME<br><b>John W. Mathews</b>  |                                  | 16. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>  |  |
| 17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>No</b>   |                                  | 18. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |  |
| 19. SOCIAL SECURITY NO.  |                                  | 20. MOTHER'S MAIDEN NAME<br><b>Barbour E. Mathews</b>   |  |
| 21. INFORMANT<br><b>Mrs. Helen Sanks-1913 Division St.</b>   |                                  | 22. ADDRESS   |  |
| 23. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Pneumonia, extensive</b> |                                  | 24. INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b>   |  |
| 25. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Cerebral Apoplexy</b>   |                                  | 26. <b>2 wks.</b>   |  |
| 27. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>Hypertension</b>   |                                  | 28. <b>8 mos.</b>   |  |
| 29. DATE OF OPERATION <b>0</b>   |                                  | 30. MAJOR FINDINGS OF OPERATION   |  |
| 31. DATE OF AUTOPSY  |                                  | 32. YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 33. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                                  | 34. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 35. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                                  | 36. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  |
| 37. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                                  | 38. HOW DID INJURY OCCUR?   |  |
| 39. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.    |                                  |   |  |
| 40. SIGNATURE<br><b>Wm. L. Surry</b>   |                                  | 41. ADDRESS<br><b>1420 E. Chase</b>   |  |
| 42. DATE SIGNED<br><b>6-26-50</b>  |                                  | 43. NAME OF CEMETERY OR CREMATORY   |  |
| 44. LOCATION (City, town, or county) (State)<br><b>Balto. Co.</b>  |                                  | 45. DATE<br><b>June 28, 1950</b>  |  |
| 46. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem.</b>  |                                  | 47. FUNERAL DIRECTOR<br><b>George T. A. Gibson Sr.</b>  |  |
| 48. ADDRESS<br><b>1735 Druid Hill Ave.</b>   |                                  | 49. VS 150  |  |

83a



235  
5650BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5650  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM MARTIN VOGTMANN

2. DATE  
OF  
DEATH

24 JUNE, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

2137 McHenry St

5. Length of stay in Baltimore

42 years

6. SEX

M.

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

WIDOWED

8A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

Baking

9. FATHER'S NAME

Vogtmann

5. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

B. G. Rader

1075. Franklin St

1B. 446 X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

## II

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 1948, to \_\_\_\_\_, 1950, that I last saw the  
deceased alive on \_\_\_\_\_, 1950, and that death occurred at 11:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

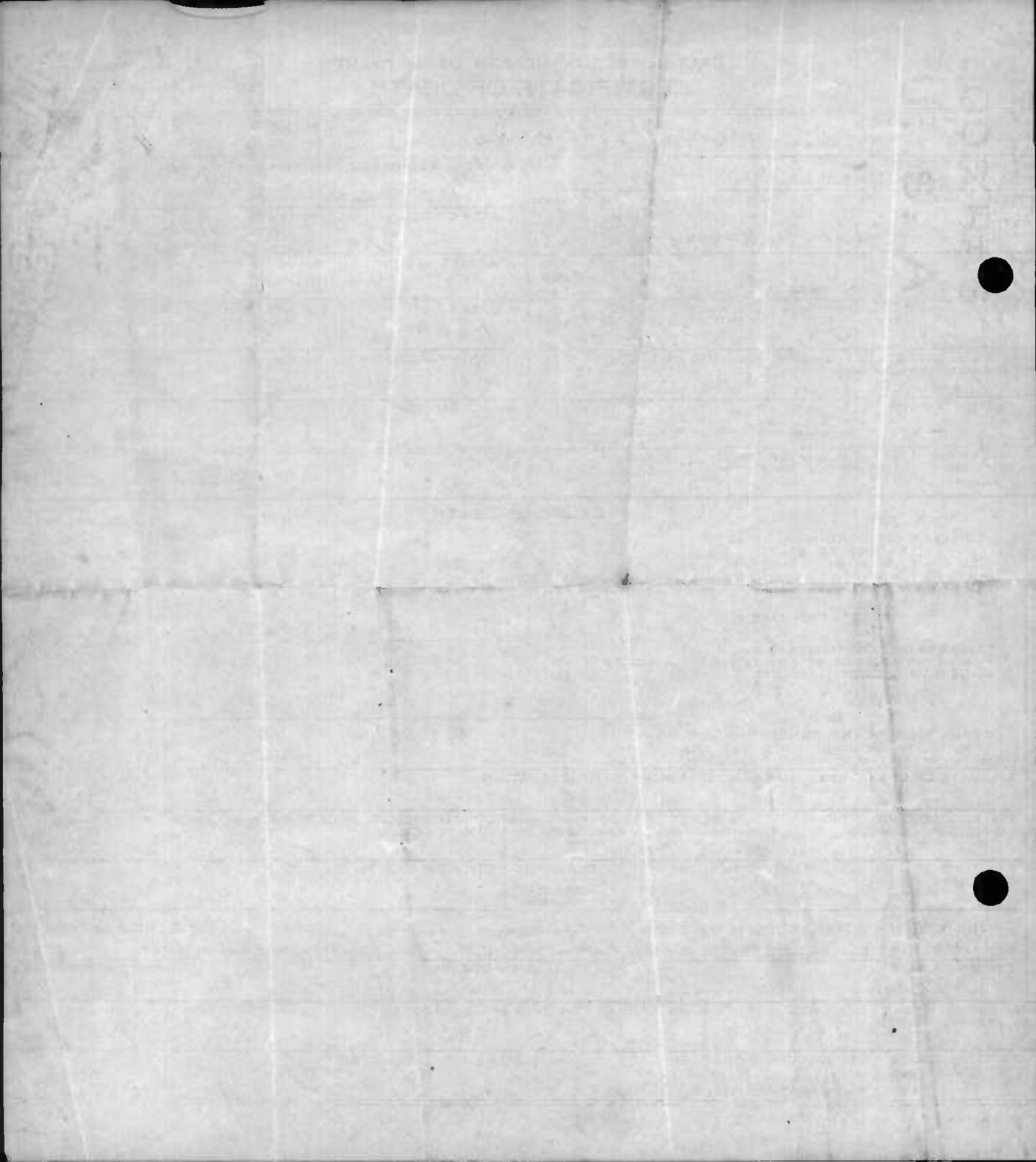
DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150



660

50 5651

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_


50 5651

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)**ERNEST E. BREWER.**2. DATE  
OF  
DEATH**JUNE 24-1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION**708 W 33<sup>rd</sup> ST**C.  Birth of stay in BaltimoreYrs.  
Mos.  
Days

5. SEX

**MALE**

6. COLOR OR RACE

**WHITE**7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)**MARRIED**

8. DATE OF BIRTH

**SEPT-6, 1894**9. AGE (In years  
last birthday)**55**# Under 1 Year  
Months: Days# Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)**OPERATOR**10B. KIND OF BUSINESS OR  
INDUSTRY**FILLING STATION**

11. BIRTHPLACE (State or foreign country)

**MARYLAND**12. CITIZEN OF  
WHAT COUNTRY?**U.S.**

13. FATHER'S NAME

**UNKNOWN**

14. MOTHER'S MAIDEN NAME

**LOUELLA ?**15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

**ROSE E. BREWER-708 W 33<sup>rd</sup> ST**18. **760X I**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

**Coronary Thrombosis**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

**Arteriosclerosis**

DUE TO

(C)

**Diabetes Mellitus**INTERVAL BETWEEN  
ONSET AND DEATHOTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Feb 1**, 19**50**, to **June 24**, 19**50**, that I last saw the  
deceased alive on **June 24**, 19**50** and that death occurred at **7:50 A. m.**, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

156 7V

61



Dr. Post  
612 Wilton Rd.

Monday - 6 to 9 P.M.

# CERTIFICATE CORRECTED

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

50 5652

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

**RICHARD L. STILLS**

2. DATE  
OF  
DEATH

**6/25/50**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

**MD. GENERAL HOSPITAL**

C. Length of stay in Baltimore

**22/RS.**

Yrs.  
Mos.  
Days

5. SEX

**MALE COLORED**

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

**SINGLE**

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**LABORER**

10B. KIND OF BUSINESS OR INDUSTRY

**BETH. STEEL CO.**

13. FATHER'S NAME

**THOMAS STILLS**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

**213-12-6007**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

**BALTIMORE**

**17. 16-04**

D. STREET ADDRESS (If rural, give location)

**1030 N. MONROE ST.**

8. DATE OF BIRTH

**5/4/08**

9. AGE (In years last birthday)

**42**

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

11. BIRTHPLACE (State or foreign country)

**HANOVER Co. Va.**

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

**MARTHA**

17. INFORMANT

ADDRESS

**EPINDER STILLS-1425 EDMONSON AVE.**

18. **E902.3**

### CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Laceration of the liver with**

~~XXXX~~ **secondary infarction**

### ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

**Fracture of the ribs**

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

**June 15, 1950**

19B. MAJOR FINDINGS OF OPERATION

**Ruptured liver with necrosis of larger portion of**

**the right lobe**

21A. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

**Industrial place**

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

**Bethlehem Steel Co., Sparrows Point**

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

**June 3, 1950**

**3:05 A.m.**

21E. INJURY OCCURRED

WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

**Brick wall fell on board throwing man to steel girder.**

22. I certify that I took charge of the remains described above, held an **Inspection & Inquiry** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

**RS Fisher**

M.D.

23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED **6/25/50**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**REMOVAL**

24B. DATE

**6/27/50**

24C. NAME OF CEMETERY OR CREMATORY

**ASHLAND**

24D. LOCATION (City, town, or county) (State)

**ASHLAND, VIRGINIA.**

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

**Thurston Williams, M.D.**

25. FUNERAL DIRECTOR

ADDRESS

**Wm. A. JACKSON-916 PENNA. AVE**

CERTIFICATE OF DEATH

Richard J. ...

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...

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*JOHN A. TYLER*

2. DATE  
OF  
DEATH

*6-23-50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

*1130 WARNER STREET*

C. Length of stay in Baltimore

*LIFE*

Yrs.  
Mos.  
Days

5. SEX

*MALE*

6. COLOR OR RACE

*COLORED*

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

*WIDOWED*

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

*LABORER*

10B. KIND OF BUSINESS OR  
INDUSTRY

*UNKNOWN*

13. FATHER'S NAME

*CHARLES TYLER*

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

*YES*

*WW. # 1.*

16. SOCIAL  
SECURITY NO.

8. DATE OF BIRTH

*1894*

9. AGE (in years  
last birthday)

*56*

If Under 1 Year  
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

*BALTIMORE, MD.*

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

*MARY EDWARDS*

17. INFORMANT

ADDRESS

*JNO. E. TYLER - 1029 So. FREMONT AVE.*

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

*Myocardial Degeneration*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

*2 hrs.*

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *6-9*, 1950 to *6-23*, 1950, that I last saw the  
deceased alive on *6-23*, 1950, and that death occurred at *6:10 A.M.*, from the causes and on the date stated above.

23A. SIGNATURE

*W. A. Jackson*

M. D.

23B. ADDRESS

*1543 Penna. Ave*

23C. DATE SIGNED

*6/26/50*

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

*BURIAL*

24B. DATE

*6-27-50*

24C. NAME OF CEMETERY OR CREMATORY

*BALTO. NATIONAL*

24D. LOCATION (City, town, or county) (State)

*BALTO. MD.*

DATE RECEIVED BY  
LOCAL REGISTRAR

*JUN 27 1950*

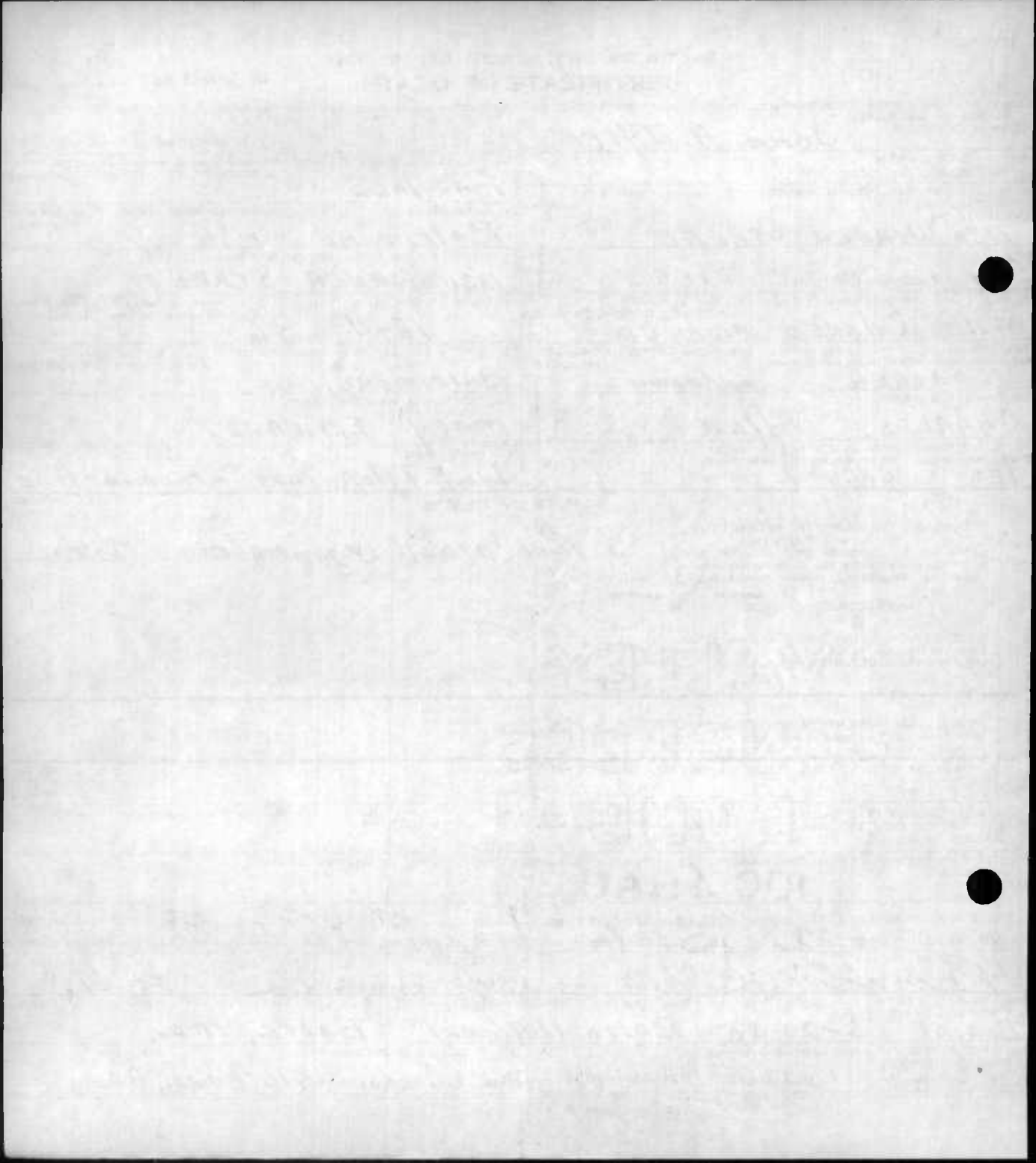
REGISTRAR'S SIGNATURE

*Wm. A. Jackson*

25. FUNERAL DIRECTOR

*Wm. A. Jackson - 916 PENNA. AVE.*

ADDRESS



260  
50 5654

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

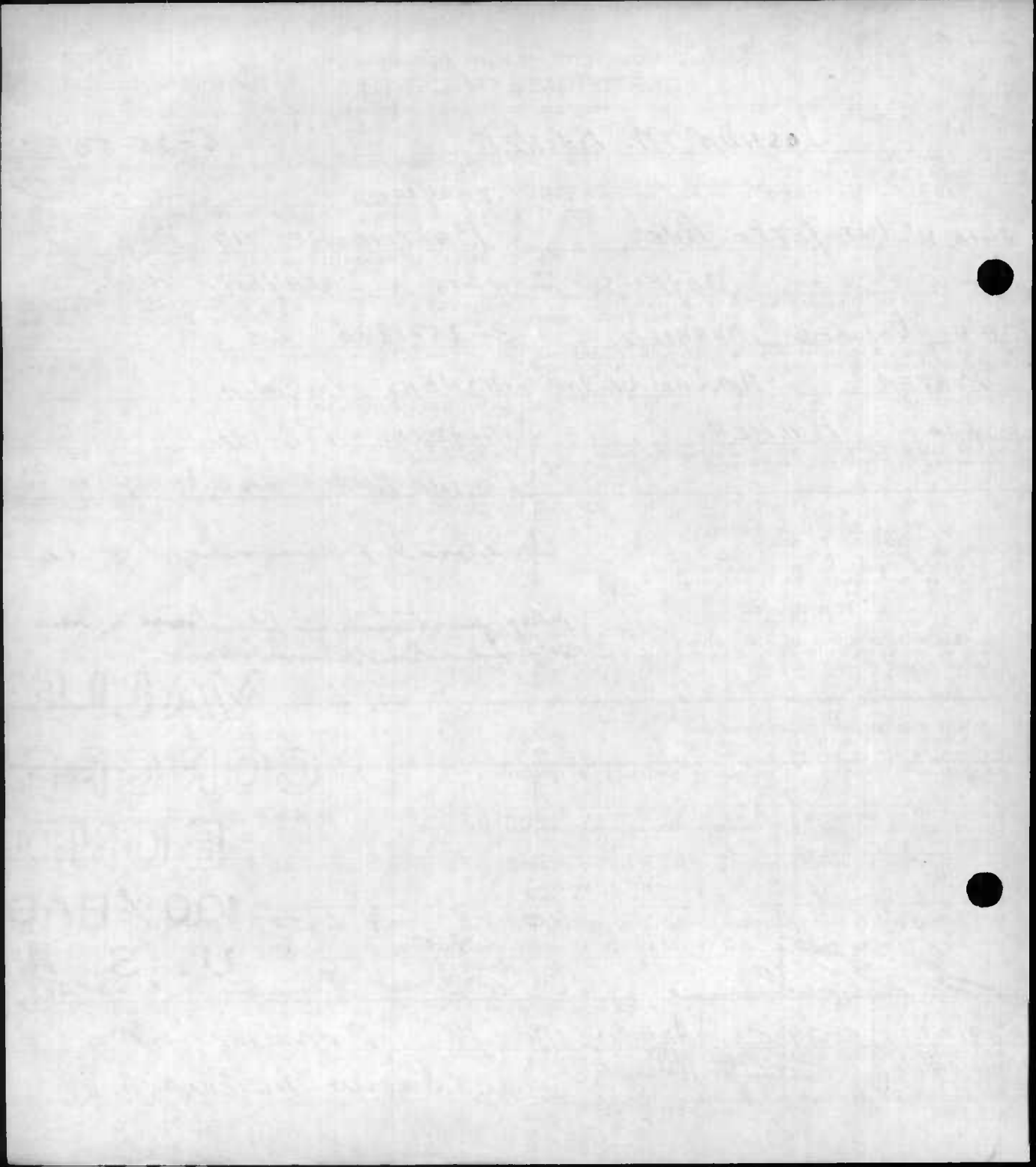
50 5654  
Registered No.

|  |                                    |   |  |
|--|------------------------------------|---|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>JOSHUA M. RUCKER</b>  |                                    | 2. DATE OF DEATH<br><b>6-25-50.</b>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>16-a3</b> |  |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>1615 W. LAFAYETTE AVE.</b>   |                                    | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTIMORE 17.</b>  |  |
| 6. Length of stay in Baltimore<br><b>20 YEARS</b>  |                                    | D. STREET ADDRESS (If rural, give location)<br><b>1615 W. LAFAYETTE AVE.</b>  |  |
| 7. SEX<br><b>MALE</b>  | 8. COLOR OR RACE<br><b>COLORED</b> | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>MARRIED</b>   | 10. B. DATE OF BIRTH<br><b>3-28-1890</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>PORTER</b>   |                                    | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>AM. CAN. CO. INC.</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>AMHERST, VIRGINIA</b>  |                                    | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME<br><b>JOSHUA RUCKER</b>  |                                    | 14. MOTHER'S MAIDEN NAME<br><b>MINERVA BROWN</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>Yes, no or unknown</b>   |                                    | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>BERTHA RUCKER-1615 W. LAFAYETTE AVE.</b>   |                                    | ADDRESS   |  |
| 18. <b>442X</b> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cerebral Hemorrhage</b><br>DUE TO<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>My pertensian Cardiovascular Renal Disease</b><br>DUE TO<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>3 days</b> |                                    |   |  |
| 19A. DATE OF OPERATION <b>0</b>  |                                    | 19B. MAJOR FINDINGS OF OPERATION  |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                    |   |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                                    | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                                    |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                    | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK AT WORK <input type="checkbox"/>  |  |
| 21F. HOW DID INJURY OCCUR?   |                                    |   |  |
| 22. I hereby certify that I attended the deceased from <b>10-13</b> , 19 <b>49</b> to <b>6-25</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>6-25</b> , 19 <b>50</b> , and that death occurred at <b>9:30 a.m.</b> , from the causes and on the date stated above.  |                                    |   |  |
| 23A. SIGNATURE<br><b>[Signature]</b>   |                                    | 23B. ADDRESS<br><b>803 N. French</b>  |  |
| 23C. DATE SIGNED<br><b>6-26-50</b>   |                                    |   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                    | 24B. DATE<br><b>6-29-50</b>   |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>ARBUTOS MEM. PK.</b>  |                                    | 24D. LOCATION (City, town, or county) (State)<br><b>BALTIMORE. Co. MD.</b>  |  |
| 25. FUNERAL DIRECTOR<br><b>Wm. A. JACKSON - 916 PENNA. AVE.</b>  |                                    | ADDRESS   |  |

7503V

131a





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50-5655

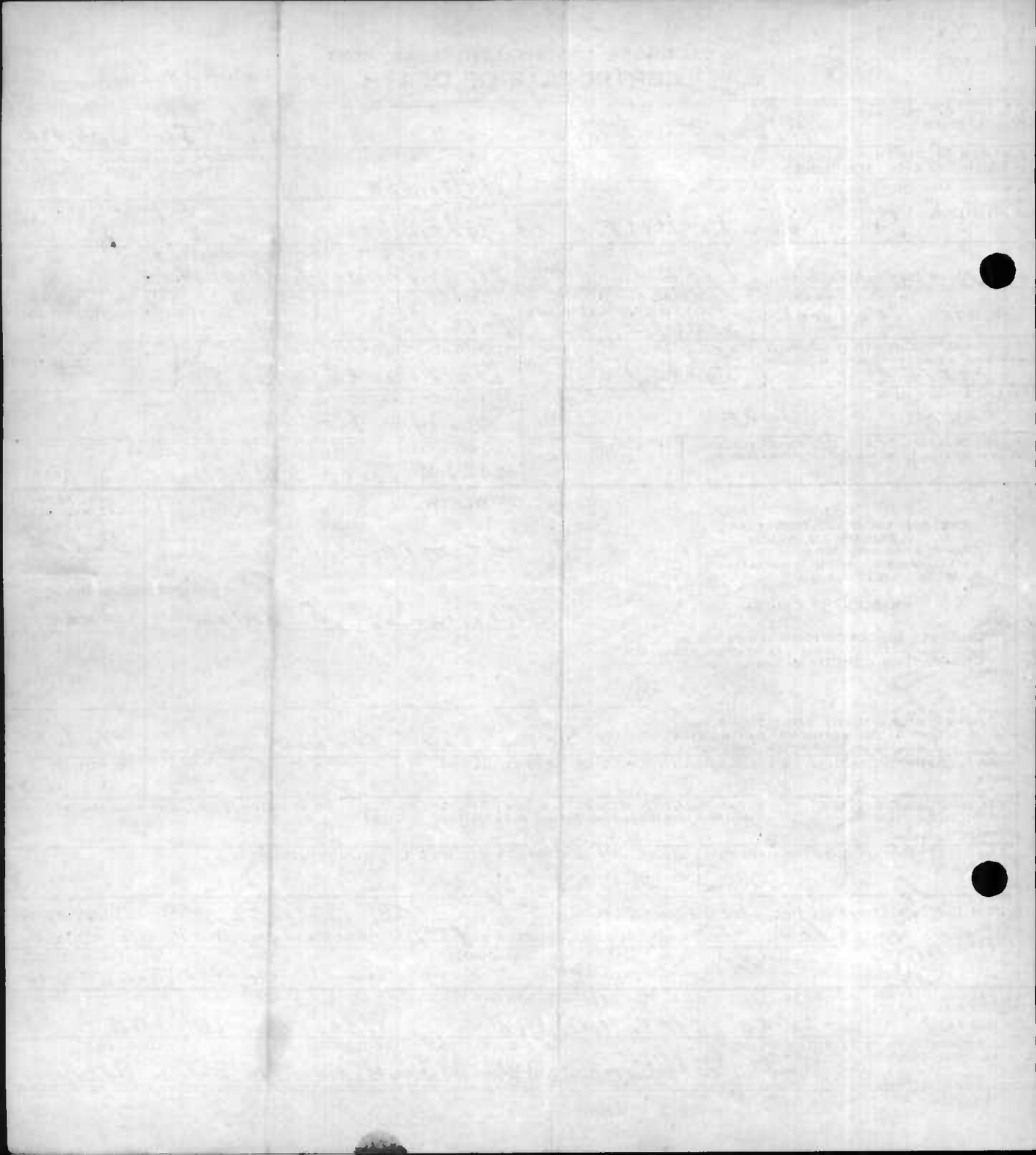
600  
50 5655  
BIRTH NO.

|  |                                    |  |   |  |  |
|--|------------------------------------|--|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <u>Albert Ware</u>  |                                    |  | 2. DATE OF DEATH<br><u>June 24, 1950</u>  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                    |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>BALTIMORE</u><br>B. COUNTY _____ |  |  |
| 5. FULL NAME OF (If not in hospital or institution, give street address or location)<br><u>Provident Hosp.</u> |                                    |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><u>BALTIMORE 17-02</u>                                |  |  |
| 6. LENGTH OF STAY IN BALTIMORE <u>LIFE</u>   |                                    |  | D. STREET ADDRESS (If rural, give location)<br><u>1119 PENNSYLVANIA AVE</u>   |  |  |
| 5. SEX<br><u>male</u>  | 6. COLOR OR RACE<br><u>Colored</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><u>SINGLE</u> | 8. DATE OF BIRTH<br><u>4-1-1900</u>   | 9. AGE (in years last birthday)<br><u>50</u> | 10. CITIZEN OF WHAT COUNTRY?<br>If Under 1 Year: Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>FOSTER</u>   |                                    |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>TAVERN</u>  |  |  |
| 13. FATHER'S NAME<br><u>JOHN WARE</u>  |                                    |  | 12. CITIZEN OF WHAT COUNTRY?<br>11. BIRTHPLACE (State or foreign country)<br><u>BALTIMORE, MO.</u>                                    |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)        |                                    |  | 16. SOCIAL SECURITY NO.   |  |  |
| 17. INFORMANT<br><u>MARY W. FOOTE, 726 WILMER COURT</u>  |                                    |  | ADDRESS   |  |  |

|   |  |                                      |   |
|---|--|--------------------------------------|---|
| 18. <u>153X</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><u>Uremia.</u> |  | CAUSE OF DEATH<br>(A) <u>Uremia.</u> | INTERVAL BETWEEN ONSET AND DEATH<br><u>Undet.</u> |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><u>Carcinoma of colon</u>   |  | (B) <u>Carcinoma of colon</u>        | <u>Undet.</u>                                     |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><u>Secondary Anemia</u>  |  | (C) <u>Secondary Anemia</u>          | <u>Undet.</u>                                     |

|  |   |  |  |   |
|--|---|--|--|---|
| 19A. DATE OF OPERATION <u>6/24/50</u>  |   | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |   |
| 21D. TIME (Month) (Day) (Year) (Hour)  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |   |
| 22. I hereby certify that I attended the deceased from <u>5/31, 1950</u> , to <u>6/24, 1950</u> , that I last saw the deceased alive on <u>6/24, 1950</u> , and that death occurred at <u>7:45</u> am, from the causes and on the date stated above. |   |  |  |   |

|  |   |  |  |  |
|--|---|--|--|--|
| 23A. SIGNATURE<br><u>Thurmond Thompson, M.D.</u>           |   | 23B. ADDRESS<br><u>Provident Hosp.</u>                         |  | 23C. DATE SIGNED<br><u>June 24, 1950</u> |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u> | 24B. DATE<br><u>6-28-50</u>                             | 24C. NAME OF CEMETERY OR CREMATORY<br><u>MT. AUBURN</u>        | 24D. LOCATION (City, town, or county) (State)<br><u>BALTIMORE, MO.</u> |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><u>June 27, 1950</u>   | REGISTRAR'S SIGNATURE<br><u>Thurmond Thompson, M.D.</u> | 25. FUNERAL DIRECTOR<br><u>Wm. A. JACKSON - 916 PENN. AVE.</u> |  |  |



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 5656**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

**BARBARA MAGDELEN RYMKIEWICZ**

2. DATE  
OF  
DEATH

**June 25, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland **Pine Ridge Conv. Home**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

**Harford Road**

C. Length of stay in Baltimore

**life**

Yrs.  
Mos.  
Days

5. SEX

**female**

6. COLOR OR RACE

**white**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

**single**

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**none**

10B. KIND OF BUSINESS OR INDUSTRY

**at home**

13. FATHER'S NAME

**Joseph Rymkiewicz**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

**no**

16. SOCIAL SECURITY NO.

8. DATE OF BIRTH

**Dec. 4, 1900**

9. AGE (In years last birthday)

**49**

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

**Baltimore, Md.**

12. CITIZEN OF WHAT COUNTRY?

**U.S.**

14. MOTHER'S MAIDEN NAME

**Anna Kasprovicz**

17. INFORMANT

ADDRESS

**Miss Theresa Rymkiewicz, sister, above**

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

**Cancer of Rectum**

INTERVAL BETWEEN ONSET AND DEATH

**18 months**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office hldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **June 24, 1950**, to **June 25, 1950**, that I last saw the deceased alive on **June 24, 1950**, and that death occurred at **6:30 A.M.** from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

**Burial**

**June 28, 1950**

**Holy Rosary Cemetery**

**German Hill Rd., Balto. Md.**

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

**JUN 27 1950**

**Wilmington Williams, M.D.**

**Schimunek Funeral Home, Inc.  
2601-3-5 E. Madison St.**



525  
50 5657BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5657

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Clyde R. Benson

2. DATE  
OF  
DEATH

6-26-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION  
(If not in hospital or institution, give street address or location)

13 South Baltimore General Hospital

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Nov. 10, 1917

9. AGE (In years,  
last birthday)

32

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Mechanic, Disabled

10B. KIND OF BUSINESS OR  
INDUSTRY

U.S. ARMY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

C.L. Benson

14. MOTHER'S MAIDEN NAME

Gertrude Buell

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

Yes

(If yes, give war or dates of service)

WW 2

16. SOCIAL  
SECURITY NO.

xxx

17. INFORMANT

ADDRESS

Mrs Clyde Benson, 6716 Campfield Road

18. 592X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) ACUTE PULMONARY EDEMA

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) HYPERTENSIVE CARDIOVASCULAR DISEASE

DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) CHRONIC GLOMERULONEPHRITIS

RENAL LITHIASIS

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/25, 1950, to 6/26, 1950, that I last saw the deceased alive on 6/26, 1950, and that death occurred at 3:40 P.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

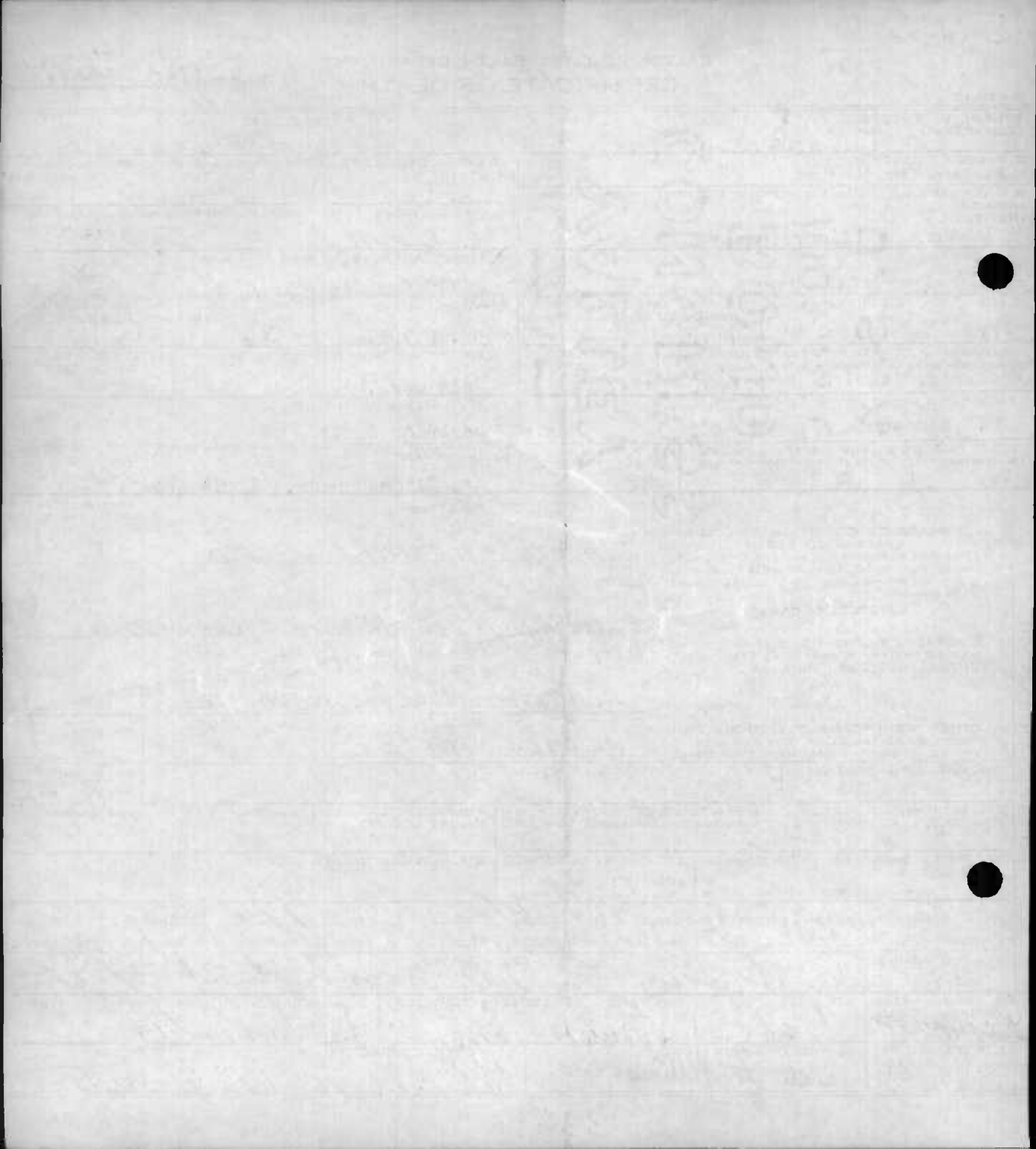
DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5658  
Registered No.

BIRTH NO.

|   |                               |   |   |  |   |
|---|-------------------------------|---|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>ISAAC BRYAN PHOEBUS</b>   |                               |   | 2. DATE OF DEATH <b>June 25, 1950</b>   |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                               |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>Baltimore</b> |  |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>South Baltimore General Hospital</b> |                               |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 22-01</b>  |  |   |
| C. Length of stay in Baltimore<br>Yrs.<br>Mos.<br>Days  |                               |   | D. STREET ADDRESS (If rural, give location)<br><b>118 W. Lee Street</b>   |  |   |
| 5. SEX <b>male</b>  | 6. COLOR OR RACE <b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b> | 8. DATE OF BIRTH<br><b>Oct 12, 1896</b>   |  | 9. AGE (In years last birthday) <b>53</b><br>If Under 1 Year Months Days If Under 24 Hours Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Carpenter, Unemployed</b>     |                               | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>House</b>                 | 11. BIRTHPLACE (State or foreign country)<br><b>Somerset Co., Md.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?  |
| 13. FATHER'S NAME<br><b>David Phoebus</b>   |                               |   | 14. MOTHER'S MAIDEN NAME<br><b>Bertha Austin</b>  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>No</b>                                |                               | 16. SOCIAL SECURITY NO.<br><b>None</b>                            | 17. INFORMANT ADDRESS<br><b>Edgar D. Phoebus, 2601 Greenmount Ave.</b>  |  |   |

|   |  |                                  |
|---|--|----------------------------------|
| 18. <b>E-931.0</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Heat stroke</b><br>(A) DUE TO |  | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>(B) DUE TO   |  |                                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(C) DUE TO   |  |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |                                  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 19A. DATE OF OPERATION  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Home</b>  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>118 W. Lee Street 22/1</b> |  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br><b>June 24, 1950</b>   |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?<br><b>Apparently became overheated during hot afternoon and evening</b>        |  |
| 22. I certify that I took charge of the remains described above, held an <b>autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |  |   |  |   |  |
| 23A. SIGNATURE<br><i>Stanley V. Dunsen</i> M.D.   |  | 23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/> |  | 23C. DATE SIGNED<br><b>June 26, 1950</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>6/28/50</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Meadow Ridge</b>   |  |
| 24D. LOCATION (City, town, or county)<br><b>Dorsey, Md.</b>   |  | 24E. LOCATION (State)<br><b>Dorsey, Md.</b>   |  | 24F. LOCATION (City, town, or county)<br><b>Dorsey, Md.</b>   |  |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>IN 27 1950</b> |  | REGISTRAR'S SIGNATURE<br><i>Christington Williams, M.D.</i> |  | 25. FUNERAL DIRECTOR<br><i>Wm. (S) 1219 St Paul St</i> |  |
| S 151   |  | N-981.0   |  | 30849  |  |
|   |  |   |  | 191  |  |



500  
50 5659BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5659  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM G. REMMEY

2. DATE  
OF  
DEATH

June 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 201 Chesapeake Ave

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

C. Length of stay in Baltimore

55 Yrs.  
Mos-  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Aug. 12, 1894

9. AGE (in years  
last birthday)

55

10. Under 1 Year  
Months: Days: Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

SHIPPING CLERK LUMBER YARD

10B. KIND OF BUSINESS OR  
INDUSTRY

13. FATHER'S NAME

William Remmey

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

yes 1st World War

16. SOCIAL  
SECURITY NO.

215-09-4896

14. MOTHER'S MAIDEN NAME

Theresa Chaney

17. INFORMANT

Marie A. Remmey 201 Chesapeake Ave

ADDRESS

18. 181X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Papillary carcinoma  
of the bladder.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Haemia.

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN  
ONSET AND DEATHJan. 10  
19482-3  
months.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 10, 1948, to June 26, 1950, that I last saw the  
deceased alive on 3/27, 1950, and that death occurred at 12:45 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Harry Deibel

M. D.

23B. ADDRESS

1226 Hanover St.

23C. DATE SIGNED

6/26/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

June 29, 1950

24C. NAME OF CEMETERY OR CREMATORY

Cedar Hill

24D. LOCATION (City, town, or county)

A. A. Co. Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

JUN 27 1950

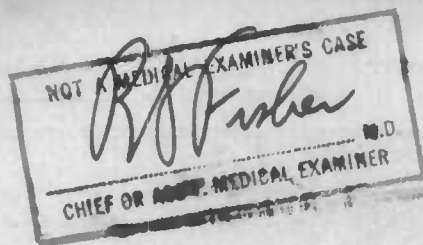
REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Mr. John W. Truitt, 5311 Edmondson Ave

ADDRESS



-600

50 5660

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5660

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

GARY, Clarence Edward, Sr.

2. DATE  
OF  
DEATH

6/25/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

University Hospital

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Operator-Owner

10B. KIND OF BUSINESS OR  
INDUSTRY

Gasoline Station

13. FATHER'S NAME

Junius Gary

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

no

8. DATE OF BIRTH

Aug. 19, 1887

9. AGE (In years  
last birthday)11 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.

62

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Eliza M. Mears

17. INFORMANT

Mrs. Ida C. Gary- 7th St. Green Haven, Pasadena, A. A. Co.

18. 330X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Subarachnoid Hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Hypertensive Cardio-Vasc Disease

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/14 1950, to 6/25 1950, that I last saw the  
deceased alive on 6/25 1950, and that death occurred at 538 P. m., from the causes and on the date stated above.

23A. SIGNATURE

James M. Biscanar

M. D.

23B. ADDRESS

University Hospital

23C. DATE SIGNED

6/25/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

6/29/50

24C. NAME OF CEMETERY OR CREMATORY

Glen Haven Cem.

24D. LOCATION (City, town, or county)

A. A. Co., Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

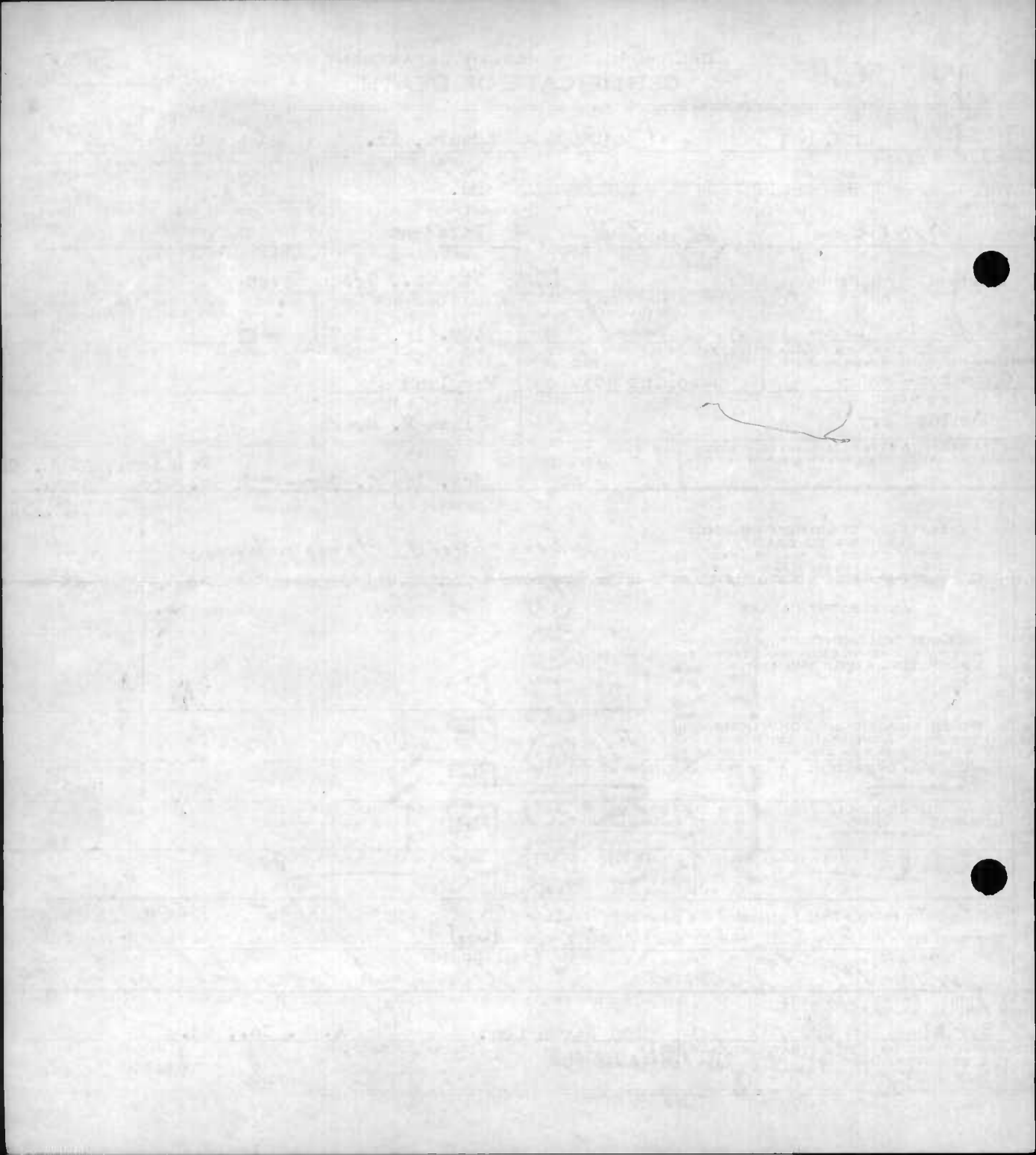
Huntington Williams, M.D.

25. FUNERAL DIRECTOR

J. L. Lickner &amp; Son - Balt - Md.

ADDRESS





636

50 5661

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 5661  
Registered No.

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| BIRTH NO.  |  | 1. NAME OF DECEASED<br>(Type or Print)   |  | 2. DATE OF DEATH   |  |
|  |  | HARRIETT M. CARTER   |  | June 24, 1950  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)    |  |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)   |  | A. STATE<br>Md.  |  |  |  |
| HOSPITAL OR INSTITUTE 3402 Clifton Ave.  |  | B. COUNTY  |  |  |  |
| C. Length of stay in Baltimore   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)             |  |  |  |
| Yrs. Mos. Days   |  | Baltimore 15-08B   |  |  |  |
| 5. SEX   |  | D. STREET ADDRESS (If rural, give location)  |  |  |  |
| female   |  | 3402 Clifton Ave.  |  |  |  |
| 6. COLOR OR RACE   |  | 8. DATE OF BIRTH   |  |  |  |
| white  |  | Oct. 10, 1880  |  |  |  |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  |  | 9. AGE (In years last birthday)  |  | 11. BIRTHPLACE (State or foreign country)                                |  |
| widowed  |  | 69   |  | Maryland   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| saleslady Rtd.   |  | Department Store   |  |  |  |
| 13. FATHER'S NAME  |  | 14. MOTHER'S MAIDEN NAME   |  |  |  |
| James E. Sturgeon  |  | Amelia D. Benjamin   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  |
| no   |  | 216-01-5975  |  | Mrs. Virginia C. Stancill 3402 Clifton Ave                               |  |
| 18. 420.1  |  | CAUSE OF DEATH   |  |  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)                                 |  | (A) Anterior Coronary Thrombosis   |  |  |  |
| ANTECEDENT CAUSES  |  | DUE TO arteriosclerosis (advanced)   |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  | (B) Arterio Sclerosis  |  |  |  |
| II   |  | (C)  |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |  |  |  |  |
| 19A. DATE OF OPERATION   |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?   |  |
| none   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| none   |  |  |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED   |  | 21F. HOW DID INJURY OCCUR?   |  |
| INJURY   |  | WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK        |  |  |  |
| 22. I hereby certify that I attended the deceased from Jan 24, 1950, to June 24, 1950, that I last saw the deceased alive on June 23, 1950, and that death occurred at 4 p.m., from the causes and on the date stated above. |  |  |  |  |  |
| 23A. SIGNATURE   |  | 23B. ADDRESS   |  | 23C. DATE SIGNED   |  |
| Walter Stuibler  |  | 222 Garrison Blvd.   |  | June 24/50   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  |  | 24B. DATE  |  | 24C. NAME OF CEMETERY OR CREMATORY                                       |  |
| Burial   |  | 6/27/50  |  | Loudon Park Cem.   |  |
| 24D. LOCATION (City, town, or county)  |  | 24E. FUNERAL DIRECTOR  |  | 24F. ADDRESS   |  |
| Balto., Md.  |  | H. M. J. Eickner & Sons  |  | Balto  |  |
| DATE RECEIVED BY LOCAL REGISTRAR   |  | REGISTRAR'S SIGNATURE  |  | 25. FUNERAL DIRECTOR ADDRESS   |  |
| JUN 27 1950  |  | Huntington Williams, Jr.   |  | H. M. J. Eickner & Sons Balto  |  |

MEDICAL CERTIFICATION

29863

94a md.

CERTIFICATE OF DEATH

John Doe  
100 Main Street  
New York, N.Y.

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 5662**

**BIRTH NO.** 50 5662

|   |                                  |   |   |  |  |
|---|----------------------------------|---|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>ANNIE ELIZABETH ZIEGLER</b>   |                                  |   | 2. DATE OF DEATH<br><b>June 25, 1950</b>  |  |  |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>  |                                  |   | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <b>Md.</b><br>B. COUNTY _____ |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>214 Homewood Terrace</b>  |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 12-02</b>                          |  |  |
| C. Length of stay in Baltimore<br>Yrs. _____<br>Mos. _____<br>Days _____  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>214 Homewood Terrace</b>  |  |  |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>widowed</b> | 8. DATE OF BIRTH<br><b>April 2, 1877</b>  |  | 9. AGE (In years last birthday)<br><b>73</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>at Home</b>               | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br>_____        |
| 13. FATHER'S NAME<br><b>Sebastian Hook</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Annie E. Rice</b>  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>-</b>                                   |                                  | 16. SOCIAL SECURITY NO.<br><b>-</b>                               | 17. INFORMANT ADDRESS<br><b>Miss Alma Hook - 214 Homewood Terr.</b>   |  |  |

|   |  |
|---|--|
| 18. <b>4 yrs. 1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | CAUSE OF DEATH<br>(A) <b>Cardio Vascular Disease</b><br>DUE TO<br>(B) <b>Bronchitis</b><br>DUE TO<br>(C) <b>Anemia &amp; Debility</b><br><br>INTERVAL BETWEEN ONSET AND DEATH<br>_____ |
|---|--|

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 19A. DATE OF OPERATION <b>0</b>   |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME (Month) (Day) (Year) (Hour) MINUTE<br>INJURY  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above. |  |   |  |  |  |
| 23A. SIGNATURE<br><b>Edw E. Whitehill</b>   |  | 23B. ADDRESS<br>M. D. <b>2308 University Pkwy 18</b>  |  | 23C. DATE SIGNED<br><b>June 26/50</b>                                    |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>6/29/50</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cem.</b>            |  |
| 24D. LOCATION (City, town, or county)<br><b>Pikesville, Md.</b>   |  | 24E. DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 27 1950</b>   |  | 24F. REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b>           |  |
| 24G. FUNERAL DIRECTOR<br><b>Wm. J. Dickerson &amp; Sons</b>   |  | 24H. ADDRESS<br><b>937 Md.</b>  |  | 24I. DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 27 1950</b>              |  |

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 5663

BIRTH NO. 445

|   |                               |  |  |
|---|-------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <u>Helen J. Wilhelm</u>  |                               | 2. DATE OF DEATH<br><u>June 26, 1950</u>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                               | 4. USUAL RESIDENCE Where deceased lived. If institution: residence before admision)<br>A. STATE <u>Md</u> B. COUNTY <u>19-04</u> |  |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION <u>355. Fulton St.</u>  |                               | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><u>Baltimore</u>                                 |  |
| 6. Length of stay in Baltimore<br>Yrs. Mos. Days  |                               | D. STREET ADDRESS (If rural, give location)<br><u>355 S. Fulton Ave</u>  |  |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Married</u>  | 8. DATE OF BIRTH<br><u>1/16/1909</u>   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                           |                               | 10B. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (In years last birthday) <u>41</u><br>If Under 1 Year Months: Days: If Under 24 Hours Hours: Min. |
| 11. BIRTHPLACE (State or foreign country)<br><u>Baltimore Md</u>  |                               | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME<br><u>Joseph P. Jarboe</u>  |                               | 14. MOTHER'S MAIDEN NAME<br><u>Janie C. Carneale</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u> |                               | 16. SOCIAL SECURITY NO. <u>218-03-4007</u>   |  |
| 17. INFORMANT<br><u>Janie C. Jarboe</u>   |                               | ADDRESS <u>355 S. Fulton Ave</u>   |  |

|   |  |   |
|---|--|---|
| 18. <u>443X</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><u>Hypertensive Cardio-Vascular Disease</u> |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 yrs.</u> |
| (A) DUE TO  |  |   |
| (B) DUE TO  |  |   |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><u>II</u>   |  | (C) DUE TO  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |   |

|   |  |  |  |   |
|---|--|--|--|---|
| 19A. DATE OF OPERATION <u>6/29/50</u>   |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |   |

22. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

|   |   |  |
|---|---|--|
| 23A. SIGNATURE<br><u>Wm. H. Kammer Jr.</u> M.D. | 23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/> | 23C. DATE SIGNED<br><u>June 26, 1950</u> |
|---|---|--|

|   |   |  |  |
|---|---|--|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Cremation</u> | 24B. DATE<br><u>6/29/50</u>                       | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Meadow Edge Cx</u>        | 24D. LOCATION (City, town, or county) (State)<br><u>Baltimore Md</u> |
| DATE RECEIVED BY LOCAL REGISTRAR<br><u>JUN 27 1950</u>        | REGISTRAR'S SIGNATURE<br><u>Wm. H. Kammer Jr.</u> | 25. FUNERAL DIRECTOR<br><u>Robert M. Walter</u> ADDRESS <u>931</u> |  |



STATE OF NEW YORK

IN SENATE

JANUARY 1, 1901

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1900

ALBANY:

JOHN W. BAKER, PRINTERS

1901

240  
50 5664BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5664

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MRS. ELLEN V. HAIGLEY

2. DATE  
OF  
DEATH

6-26-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 2001 W. Fayette St.

B. FULL NAME OF (If not in hospital or institution, give street address or location)

34 Bon Secours Hosp

C. Length of stay in Baltimore

62 yrs. Mos. Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widow

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE MARYLAND

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE 20-03

D. STREET ADDRESS (If rural, give location)

1350 PAYSON ST.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

James E. Schmidt

14. MOTHER'S MAIDEN NAME

Mary A. Connolly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

ADDRESS

Mr. Paul Haigley 1350 Payson St

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

DUE TO

Pneumonia

5 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

Carcinoma of Head of Pancreas

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Embolus of Lungs

19A. DATE OF OPERATION

6-21-50

19B. MAJOR FINDINGS OF OPERATION

Carcinoma of Head of Pancreas &amp; metastases

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

INJURY

WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

22. I hereby certify that I attended the deceased from 6-17-50, 1950, to 6-26, 1950 that I last saw the deceased alive on 6-26, 1950, and that death occurred at 2 A. m., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

6-26-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

June 29-50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Cem

24D. LOCATION (City, town, or county) (State)

Baltimore Ind

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Geo. H. Berger Jr. 1512 Hollin St

STATE OF NEW YORK  
CERTIFICATE OF DEATH

FILE NO. 100-1000000000

FILE NO. 100-1000000000

|                       |  |
|-----------------------|--|
| NAME OF DECEASED      |  |
| DATE OF DEATH         |  |
| PLACE OF DEATH        |  |
| CAUSE OF DEATH        |  |
| MANNER OF DEATH       |  |
| SIGNATURE OF DECEASED |  |
| SIGNATURE OF WITNESS  |  |
| SIGNATURE OF OFFICIAL |  |
| OFFICIAL TITLE        |  |
| OFFICE                |  |
| COUNTY                |  |
| STATE                 |  |

50 5665

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5665

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mary Bell

2. DATE  
OF  
DEATH

June 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

2837 St. Paul St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY  
noneC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 12-03

C. Length of stay in Baltimore

life Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
single

8. DATE OF BIRTH

Jan. 7, 1861

9. AGE (In years,  
last birthday)

89

If Under 1 Year  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)  
schoolteacher-retired10B. KIND OF BUSINESS OR  
INDUSTRY  
Balto. City  
Public Schools

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?  
U. S.

13. FATHER'S NAME

Dr. Henry Bell

14. MOTHER'S MAIDEN NAME

Elizabeth Ann

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.17. INFORMANT  
ADDRESS  
Mary B. Waltz - 2837 St. Paul St.

18. 420.1 I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Myocarditis

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Coronary Thrombosis

DUE TO

3 mos.

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Arteriosclerosis

19A. DATE OF OPERATION

none

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

none

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January, 1948, to June 26, 1950 that I last saw the deceased alive on June 27, 1950, and that death occurred at 8:45 P. M., from the causes and on the date stated above.

23A. SIGNATURE

Nathaniel M. Beck

23B. ADDRESS

M. O. St. Paul &amp; 23rd Sts.

23C. DATE SIGNED

6-27-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)  
burial

24B. DATE

6-28-50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR  
JUN 27 1950

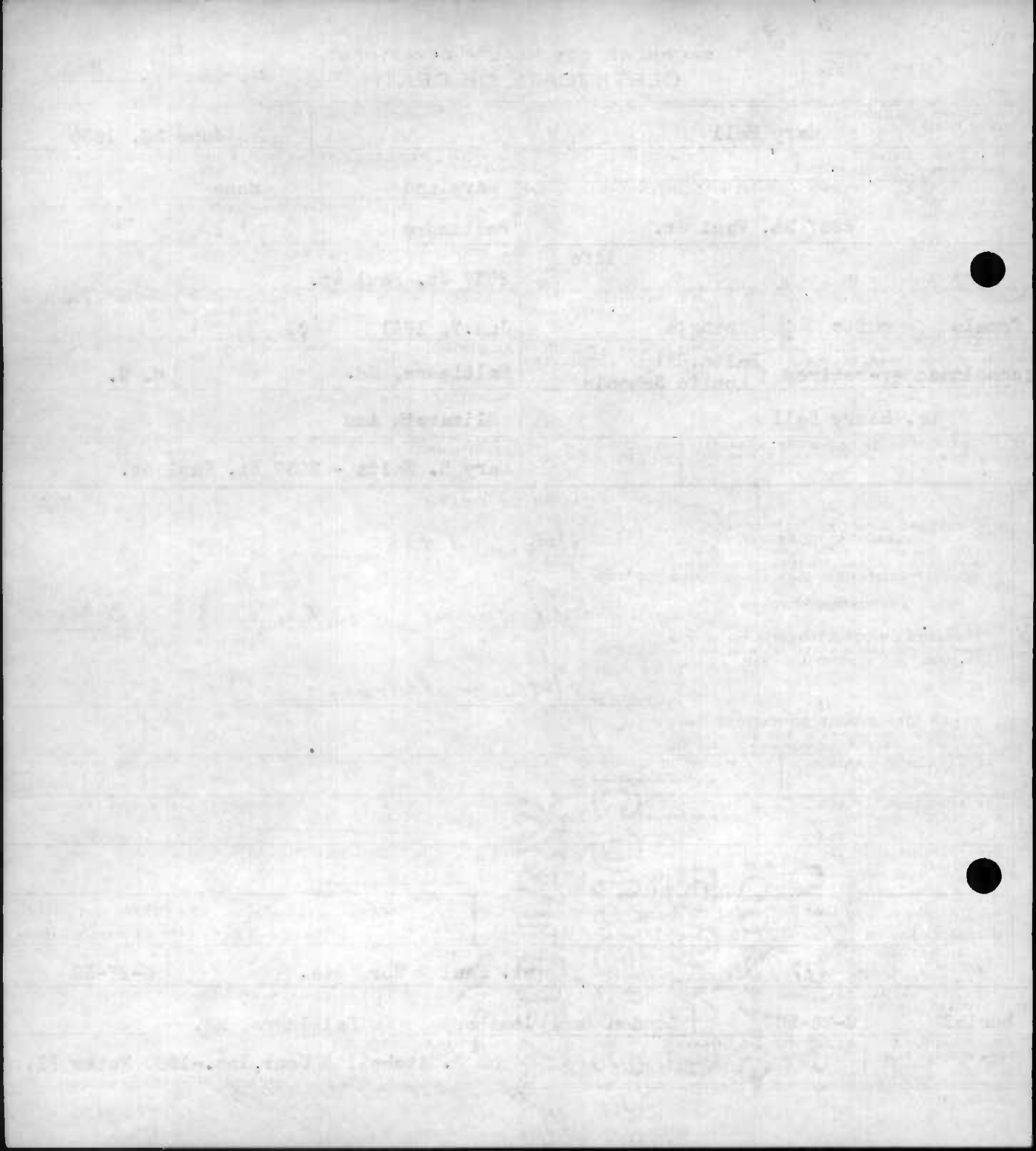
REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

John O. Mitchell &amp; Sons, Inc. - 1900 Eutaw Pl.



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5666  
Registered No. \_\_\_\_\_

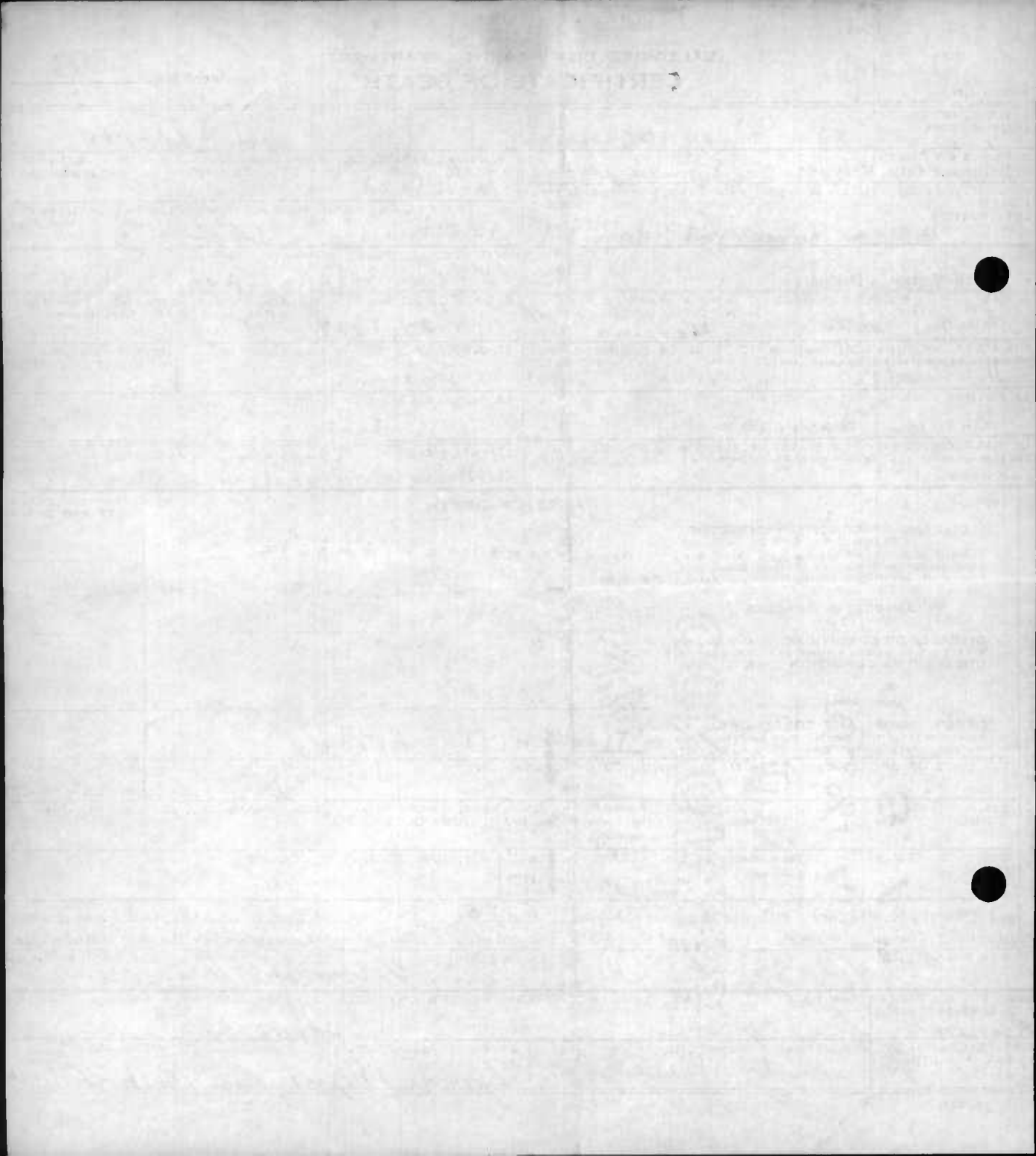
BIRTH NO. \_\_\_\_\_

|   |                                  |   |  |  |   |
|---|----------------------------------|---|--|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <u>Ida Mary Nicholson</u>  |                                  |   | 2. DATE OF DEATH <u>6/26/50</u>  |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <u>Baltimore, Md.</u>   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <u>Maryland</u><br>B. COUNTY _____ |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><u>Union Memorial Hospital</u>                                       |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><u>Baltimore 27-13</u>                               |  |   |
| c. Length of stay in Baltimore<br>Yrs. _____<br>Mos. _____<br>Days _____  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><u>5713 Roland Ave.</u>   |  |   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Married</u> | 8. DATE OF BIRTH<br><u>Apr. 24, 1877</u>   |  | 9. AGE (In years last birthday) <u>71</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY _____                           | 11. BIRTHPLACE (State or foreign country)<br><u>Indiana</u>  |  | 12. CITIZEN OF WHAT COUNTRY? _____        |
| 13. FATHER'S NAME<br><u>Melvin Harrison</u>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><u>Teeters</u>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><u>unknown</u>                             |                                  | 16. SOCIAL SECURITY NO. _____                                     | 17. INFORMANT (Husband) ADDRESS<br><u>William O. Nicholson - Same</u>  |  |   |

|   |   |   |
|---|---|---|
| 18. <u>491X</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | CAUSE OF DEATH<br>(A) <u>Bronchopneumonia</u><br>DUE TO _____<br><br>(B) _____<br>DUE TO _____<br><br>(C) <u>Bronchial Asthma</u> | INTERVAL BETWEEN ONSET AND DEATH<br>_____ |
|---|---|---|

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 19A. DATE OF OPERATION <u>0</u>   |  | 19B. MAJOR FINDINGS OF OPERATION _____   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____        |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____   |  | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK |  | 21F. HOW DID INJURY OCCUR? _____   |  |
| 22. I hereby certify that I attended the deceased from <u>6/26</u> , 19 <u>50</u> , to <u>6/26</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>6/26</u> , 19 <u>50</u> , and that death occurred at <u>7:45</u> P.m., from the causes and on the date stated above. |  |  |  |  |  |
| 23A. SIGNATURE<br><u>V. F. Cox 3rd</u>  |  | 23B. ADDRESS<br><u>Union Memorial Hospital</u>   |  | 23C. DATE SIGNED<br><u>6/26/50</u>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>   |  | 24B. DATE<br><u>June 26/50</u>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Indianapolis Ind.</u>                   |  |
| 24D. LOCATION (City, town, or county) (State)<br><u>Indianapolis Ind.</u>   |  | 25. FUNERAL DIRECTOR ADDRESS<br><u>Thomas J. Kearney Inc. 1600 Hollins</u>                             |  |  |  |





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

50 5687

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Mary Wilkins*

2. DATE  
OF  
DEATH

*June 24, 1950*

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

*2239 Madison Ave*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

*Md.*

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Baltimore 13-03*

D. STREET ADDRESS (If rural, give location)  
Yrs. Mos. Days

*2239 Madison Ave*

5. SEX

*Female*

6. COLOR OR RACE

*Colored*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*Widowed*

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Housewife*

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

*Samuel Newman*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

DUE TO

*Arteriosclerosis of Heart Disease 3 months*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

*Generalized Arteriosclerosis 6 months*

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

DUE TO

*Fractured Right Femur 3 months*

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *April 24, 1950* to *June 24, 1950*, that I last saw the deceased alive on *June 24, 1950*, and that death occurred at *2:30 p. m.*, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

*Dr. Andrew Higgins*

*2239 Madison Ave*

*6-26-50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*June 27, 1950*

*Wilmington, Delaware*

*Mrs. Robert A. Elliott & Daughter*

The activities, the heart disease  
and the fractured femur  
are of same duration.

Would you please indicate  
which, in your opinion,  
would most likely be the  
underlying cause of death.

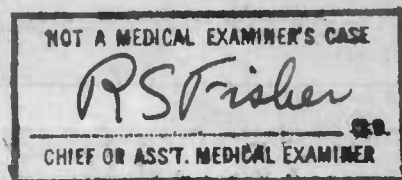
fractured femur  
be in Part II (contribution to

the death, but not related to

the disease or condition causing it) ?

See Document File 50 - 5667

9-14-50  
ES



96-1806C

2400  
50 5668

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5668

|  |                               |  |   |   |  |
|--|-------------------------------|--|---|---|--|
| BIRTH NO.  |                               | 1. NAME OF DECEASED<br>(Type or Print) <i>Lillian L. Kiel</i>  |   | 2. DATE OF DEATH<br><i>June 25, 1950</i>  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                               | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Md.</i> B. COUNTY   |   |   |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>2909 Westfield Ave.</i>  |                               | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Balto. 27-07</i>  |   |   |  |
| C. Length of stay in Baltimore   |                               | D. STREET ADDRESS (If rural, give location)<br><i>2909 Westfield</i>   |   |   |  |
| 5. SEX<br><i>F.</i>  | 6. COLOR OR RACE<br><i>W.</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>married</i>  | 8. DATE OF BIRTH<br><i>Jan 11, 1907</i> | 9. AGE (In years last birthday)<br><i>43</i>  | 10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>  |                               | 10B. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)<br><i>Baltimore</i>                       |  |
| 12. CITIZEN OF WHAT COUNTRY?   |                               | 13. FATHER'S NAME<br><i>William T. Miller</i>  |   | 14. MOTHER'S MAIDEN NAME<br><i>Lillie May Tucker</i>                                |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><i>no</i>   |                               | 16. SOCIAL SECURITY NO.<br><i>none</i>   |   | 17. INFORMANT ADDRESS<br><i>Howard Kiel, 2909 Westfield</i>                         |  |
| 18. <i>170x</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. |                               | CAUSE OF DEATH<br>(A) <i>Adenocarcinoma metastatic</i><br>DUE TO <i>Cerebral - left side.</i><br>(B) <i>Adenocarcinoma of Rt</i><br>DUE TO <i>heart (removed)</i><br>(C) <i>none</i> |   | INTERVAL BETWEEN ONSET AND DEATH<br><i>May 16, 1950</i><br><br><i>April 1950.</i>   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><i>none</i>   |                               |  |   |   |  |
| 19A. DATE OF OPERATION<br><i>May 22/50.</i>  |                               | 19B. MAJOR FINDINGS OF OPERATION<br><i>Large Adenocarcinoma of head (Dr. Thompson).</i>  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  |                               | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                               | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <i>1946</i> to <i>June 25</i> , 1950, that I last saw the deceased alive on <i>June 24</i> , 1950, and that death occurred at <i>8:22 p.m.</i> , from the causes and on the date stated above.  |                               |  |   |   |  |
| 23A. SIGNATURE<br><i>James Edmund White</i>  |                               | 23B. ADDRESS<br><i>2214 Sanford Rd.</i>  |   | 23C. DATE SIGNED<br><i>June 28/50.</i>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                               | 24B. DATE<br><i>June 28/50</i>   |   | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Western</i>                                |  |
| 24D. LOCATION (City, town, & county) (State)<br><i>Edmondson Ave Md</i>  |                               | 24E. DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUN 27 1950</i>  |   | 24F. REGISTRAR'S SIGNATURE<br><i>William Williams, M.D.</i>                         |  |
| 24G. FUNERAL DIRECTOR<br><i>Mildred J. Bleght</i>  |                               | 24H. ADDRESS<br><i>6009 Sanford Rd.</i>  |   | 24I. DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUN 27 1950</i>                         |  |

MEDICAL CERTIFICATION

5214 Harford. 6 to 8 - 9 - 10 AM.

Dr. white

88

Cl. 3000

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No.

50 5669

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*John Edward Roney*

2. DATE  
OF  
DEATH

*June 25, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

*3008 Roypton Ave*

4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)

A. STATE *Md.*

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Balto 27-05*

D. STREET ADDRESS (If rural, give location)

*3008 Roypton Ave*

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

*M*

6. COLOR OR RACE

*N.*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*married*

8. DATE OF BIRTH

*Nov. 18, 1874*

9. AGE (in years last birthday)

*75*

If Under 1 Year Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)

*Motorman*

10B. KIND OF BUSINESS OR INDUSTRY

*Balto. Transit*

11. BIRTHPLACE (State or foreign country)

*Baltimore*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*Frank Roney*

14. MOTHER'S MAIDEN NAME

*Laura Hambach*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

*no*

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*Mrs Caroline L. Roney 3008 Roypton*

18. *420.1 I*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

*Coronary Thrombosis*

QUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

*Arteriosclerotic lardis -*

QUE TO

*Vascular Disease*

(C)

INTERVAL BETWEEN ONSET AND DEATH

*3 days.*

*15-Nov*

*1945*

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *15-Nov 1945* to *25-June 1950*, that I last saw the deceased alive *25-June 1950*, and that death occurred at *4 P. m.*, from the causes and on the date stated above.

23A. SIGNATURE

M. O.

23B. ADDRESS

23C. DATE SIGNED

*Charles W. Edwards*

*2746 The Alameda*

*26-June-50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

*Burial*

*6/28/50*

*Baltimore*

*North Ave.*

*Md*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*JUN 27 1950*

*William Williams, M.D.*

*Medred J. Blight, 6009 Hayford Rd*



CW.  
Dr. Edmonds 2746 Alameda.  
Se 9614

Ha 0635

652  
5670BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5670

Registered No.

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Ida O. Ernst</i>  |                                  | 2. DATE OF DEATH <i>6-26-50</i>  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Maryland</i><br>B. COUNTY |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>Union Memorial Hospital</i>   |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore - 18 12-02</i>                    |  |
| C. Length of stay in Baltimore <i>65 yrs</i>  |                                  | D. STREET ADDRESS (If rural, give location)<br><i>2901 Guilford Ave.</i>   |  |
| 5. SEX<br><i>Female</i>   | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Single</i>   | 8. DATE OF BIRTH<br><i>Aug 28, 1865</i>      |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housemaid</i>   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>retired 6 yrs</i>  | 9. AGE (In years last birthday)<br><i>84</i> |
| 11. BIRTHPLACE (State or foreign country)<br><i>Germany</i>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  |
| 13. FATHER'S NAME<br><i>Gottlieb Ernst</i>  |                                  | 14. MOTHER'S MAIDEN NAME<br><i>Fredericka Boenning</i>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><i>Unknown</i>   |                                  | 16. SOCIAL SECURITY NO.<br><i>none</i>   |  |
| 17. INFORMANT<br><i>Miss Edith Menkel (Niece)</i>   |                                  | ADDRESS<br><i>2901 Guilford Ave.</i>   |  |
| 18. <i>443 X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Cardiac failure</i><br>DUE TO<br><i>Hypertensive cardiovascular disease</i><br>DUE TO<br><i>(C)</i> |                                  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| 19A. DATE OF OPERATION<br><i>6-26-50</i>  |                                  | 19B. MAJOR FINDINGS OF OPERATION   |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |  |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                                      |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                                  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                      |  |
| 21F. HOW DID INJURY OCCUR?  |                                  |  |  |
| 22. I hereby certify that I attended the deceased from <i>6-23</i> , 19 <i>50</i> , to <i>6-26</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>6-26</i> , 19 <i>50</i> , and that death occurred at <i>7:00</i> m., from the causes and on the date stated above.   |                                  |  |  |
| 23A. SIGNATURE<br><i>J. Frank Snyder, III</i>   |                                  | 23B. ADDRESS<br><i>Union Memorial Hosp.</i>  |  |
| 23C. DATE SIGNED<br><i>6/26/50</i>  |                                  |  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |                                  | 24B. DATE<br><i>June 28.50</i>   |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br><i>Loudon Park Cemetery</i>   |                                  | 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore Md.</i>  |  |
| 25. FUNERAL DIRECTOR<br><i>HENRY SANDER &amp; SONS, INC.</i>  |                                  | ADDRESS<br><i>North Ave. &amp; Broadway. Balto. Md.</i>  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUN 27 1950</i>  |                                  | REGISTRAR'S SIGNATURE<br><i>Wilmington Williams, M.D.</i>  |  |

*George F. Sander, 93D*

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR DISEASE CONTROL AND PREVENTION

NOTIFICATION OF DEATH

Form 100-10 (Rev. 10-1-80)

1. Name of deceased: \_\_\_\_\_

2. Date of death: \_\_\_\_\_

3. Place of death: \_\_\_\_\_

4. Cause of death: \_\_\_\_\_

5. Manner of death: \_\_\_\_\_

6. Signature of physician: \_\_\_\_\_

7. Signature of medical examiner: \_\_\_\_\_

8. Signature of coroner: \_\_\_\_\_

9. Signature of funeral director: \_\_\_\_\_

10. Signature of registrar: \_\_\_\_\_

11. Signature of health officer: \_\_\_\_\_

12. Signature of other official: \_\_\_\_\_

13. Signature of other official: \_\_\_\_\_

14. Signature of other official: \_\_\_\_\_

15. Signature of other official: \_\_\_\_\_

16. Signature of other official: \_\_\_\_\_

17. Signature of other official: \_\_\_\_\_

18. Signature of other official: \_\_\_\_\_

19. Signature of other official: \_\_\_\_\_

20. Signature of other official: \_\_\_\_\_

21. Signature of other official: \_\_\_\_\_

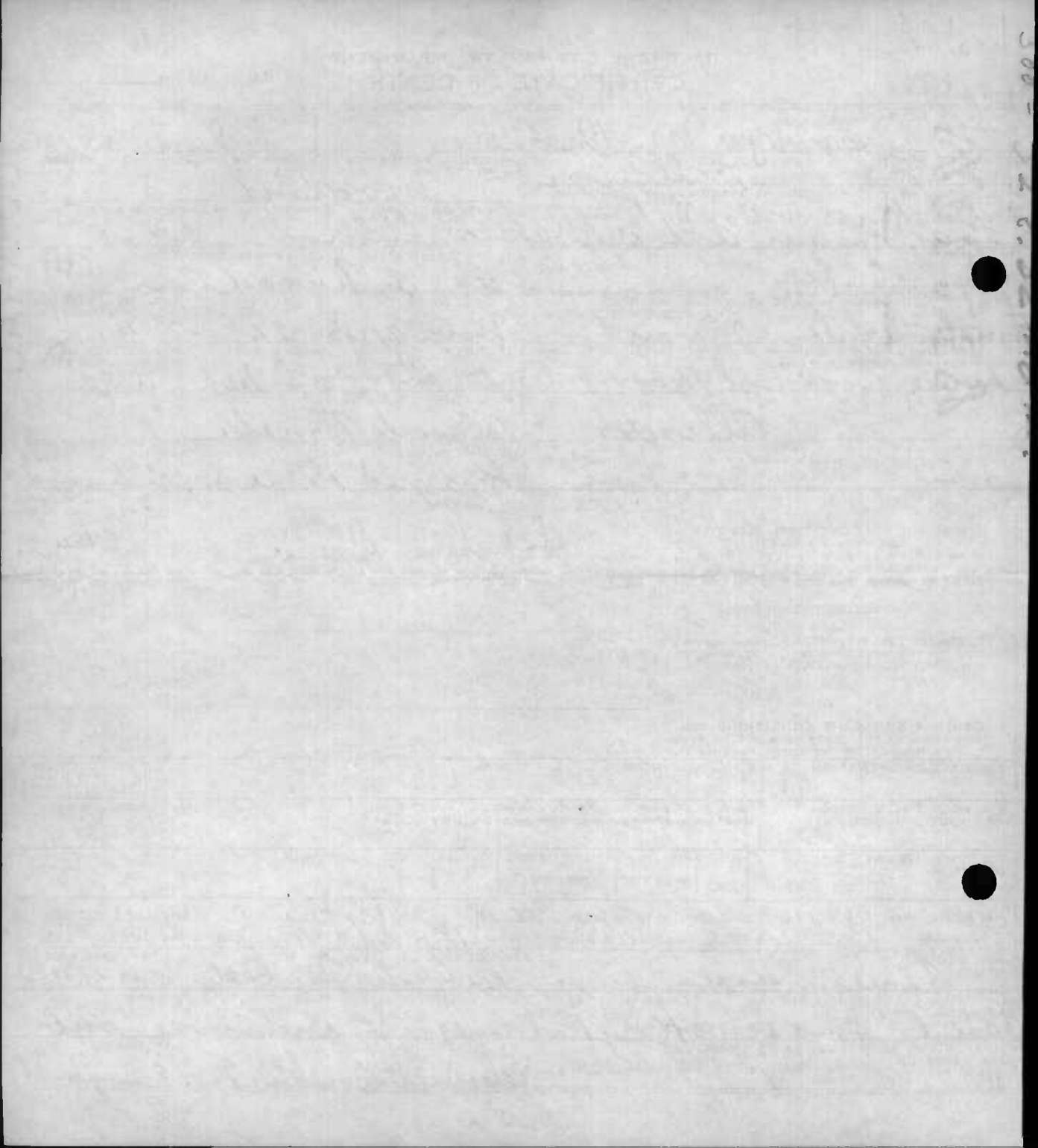
22. Signature of other official: \_\_\_\_\_

120  
5671BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5671

Registered No.

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Everlyn M. Davis</i>  |                                  | 2. DATE OF DEATH<br><i>June 25, 1950</i>  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>Baltimore</i>  |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTE <i>Kingsway Court, House</i><br><i>2601 Roslyn Ave Balto Md</i>   |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)<br><i>Baltimore</i> 27-10                     |  |
| D. STREET ADDRESS (If rural, give location)<br><i>604 Richwood Ave</i>  |                                  |   |  |
| c. Month of stay in Baltimore<br>26 Yrs. Mos. Days  |                                  |   |  |
| 5. SEX<br><i>Female</i>   | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Married</i>   | 8. DATE OF BIRTH<br><i>Nov. 10, 1923</i> |
| 9. AGE (In years last birthday)<br><i>26</i>  |                                  | 10. Under 1 Year<br>Months: <i>7</i> Days: <i>15</i>  | 11. Under 24 Hours<br>Hours: Min.        |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>House work</i>  |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>at home</i>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><i>Baltimore Md.</i>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  |
| 13. FATHER'S NAME<br><i>Allender</i>  |                                  | 14. MOTHER'S MAIDEN NAME<br><i>Blanch Friske</i>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknowns)<br><i>No</i>  |                                  | 16. SOCIAL SECURITY NO.<br><i>None</i>  |  |
| 17. INFORMANT<br><i>Harry S. Davis</i>  |                                  | ADDRESS<br><i>604 Richwood Ave</i>  |  |
| 18. <i>201X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><i>Hodgline Disease</i><br>CAUSE OF DEATH<br>(A) DUE TO<br>(B) DUE TO<br>(C) DUE TO |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><i>2 1/2 yrs.</i>   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                                  |   |  |
| 19A. DATE OF OPERATION<br><i>0</i>  |                                  | 19B. MAJOR FINDINGS OF OPERATION  |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                  |   |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                    |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                                  |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                   |  |
| 21F. HOW DID INJURY OCCUR?  |                                  |   |  |
| 22. I hereby certify that I attended the deceased from <i>Nov. 10</i> , 1949, to <i>June 25</i> , 1950 that I last saw the deceased alive on <i>June 23</i> , 1950, and that death occurred at <i>1:30</i> p.m., from the causes and on the date stated above.  |                                  |   |  |
| 23A. SIGNATURE<br><i>William E. England</i>   |                                  | 23B. ADDRESS<br><i>Med. Arts Bldg. Bldg. June 27, 1950</i>  |  |
| 23C. DATE SIGNED  |                                  |   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |                                  | 24B. DATE<br><i>June 28, 1950</i>   |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br><i>Holy Redeemer Cemetery</i>   |                                  | 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore Md.</i>   |  |
| 25. FUNERAL DIRECTOR<br><i>Edwin W. Conklin</i>   |                                  | ADDRESS<br><i>924 E. Egan St.</i>   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUN 27 1950</i>  |                                  | REGISTRAR'S SIGNATURE<br><i>Thurston Williams</i>   |  |



200  
5672BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5672

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Anna H. Jack

2. DATE  
OF  
DEATH

June 27-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

4202 Parkwood Ave

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

New York V-29

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Babylon Long Island

D. STREET ADDRESS (If rural, give location)

19 Audinore Street

5. SEX

Female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

June 27 1885

9. AGE (In years-  
last birthday)

65

10. Under 1 Year  
Months Days11. Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

at home

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William Walsh

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
Yes, no or unknown (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Wm. Jack, 19 Audinore St. N.Y.

18. 331X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Cerebral Hemorrhage

4 days

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Arteriosclerosis

DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Congestive Heart Failure

years?

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 13, 1950, to June 27, 1950, that I last saw the deceased alive on June 26, 1950, and that death occurred at 1:05 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Charles V. Shvick M.D.

3601 Ailsa Ave

6/27/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

6/30/50

St. Joseph's

Babylon, Long I. N.Y.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUN 27 1950

Christington Williams

W. J. Luck, 5305 Mayford Rd.



Dr. Surtak  
3601 Alila

420

50 5673

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5673  
Registered No.

BIRTH NO.

|  |                                |   |  |  |   |
|--|--------------------------------|---|--|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Lina (Gales) Gales</i>   |                                |   | 2. DATE OF DEATH <i>6-25-1950</i>  |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>Maryland</i>  |                                |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Maryland</i><br>B. COUNTY |  |   |
| 5. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION <i>2317 Guilford ave</i> |                                |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 12-04</i>                         |  |   |
| 6. Length of stay in Baltimore <i>45 yrs</i>   |                                |   | D. STREET ADDRESS (If rural, give location)<br><i>2317 Guilford ave</i>  |  |   |
| 7. SEX<br><i>Female</i>  | 8. COLOR OR RACE<br><i>col</i> | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Widow</i> | 10. DATE OF BIRTH<br><i>4-13-1882</i>  |  | 11. AGE (In years last birthday) <i>68</i>    |
| 12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>                           |                                |   | 13. BIRTHPLACE (State or foreign country)<br><i>Virginia</i>   |  | 14. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i> |
| 15. FATHER'S NAME<br><i>Lerr Bryant</i>  |                                |   | 16. MOTHER'S MAIDEN NAME<br><i>Maria Redd</i>  |  |   |
| 17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)  |                                |   | 18. SOCIAL SECURITY NO.  |  |   |
| 19. INFORMANT<br><i>Elizabeth Meekins</i>  |                                |   | ADDRESS<br><i>2317 Ave Guilford</i>  |  |   |

18. *442 X*  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

## CAUSE OF DEATH

(A) DUE TO

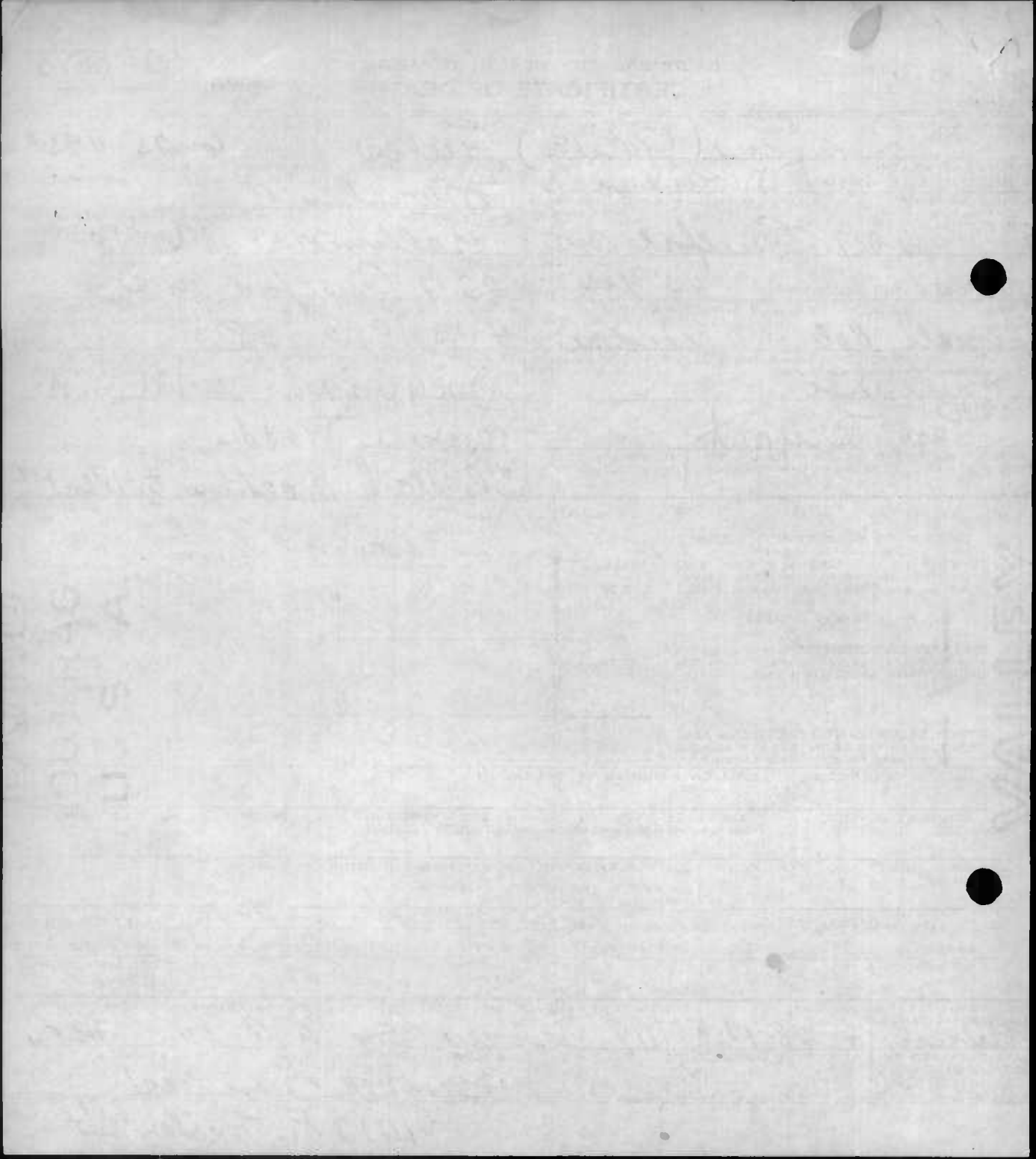
(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

*to avoid*

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 19A. DATE OF OPERATION <i>6-20</i>  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)     |  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>OCCUR  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <i>6/20</i> , 19 <i>50</i> , to <i>6/25</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>6/20</i> , 19 <i>50</i> , and that death occurred at <i>6/25</i> m., from the causes and on the date stated above. |  |   |  |  |  |
| 23A. SIGNATURE<br><i>Lina Gales</i>   |  | 23B. ADDRESS<br><i>2317 Guilford Ave</i>  |  | 23C. DATE SIGNED<br><i>June 26 1950</i>                                      |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  | 24B. DATE<br><i>6-28-1950</i>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>My Calvary Cem &amp; A. Co. Md.</i> |  |
| 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore</i>   |  | 25. FUNERAL DIRECTOR<br><i>Huntington Williams, Inc.</i>  |  | ADDRESS<br><i>Rayner Sanders 937<br/>1412 E. Preston St</i>                  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUN 27 1950</i>  |  |   |  |  |  |



425  
5674

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5674

Registered No.

|  |                                  |  |   |  |  |
|--|----------------------------------|--|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>LOTTIE H. COLLISON</b>   |                                  |  | 2. DATE OF DEATH <b>June 26, 1950</b>   |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>Baltimore</b> |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>1313 S. Hanover St.</b>  |                                  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>23-01</b>  |  |  |
| C. Length of stay in Baltimore<br>Yrs.<br>Mos.<br>Days   |                                  |  | D. STREET ADDRESS (If rural, give location)<br><b>1313 S. Hanover St.</b>   |  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widow</b>  | 8. DATE OF BIRTH<br><b>Feb. 26, 1885</b>  | 9. AGE (In years last birthday)<br><b>65</b>                             | H Under 1 Year<br>Months: Days<br>H Under 24 Hours<br>Hours: Min.        |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>Talbot County, Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?   |
| 13. FATHER'S NAME<br>(Unknown) <b>Allen</b>  |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(If yes, give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.  | 17. INFORMANT ADDRESS<br><b>Nelson Collison, Vienna, Md.</b>  |  |  |
| 18. <b>331X</b> I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Paraplegia following cerebral vascular accident.</b><br>DUE TO<br><b>Generalized arterio sclerosis</b><br>DUE TO<br><b>INTERVAL BETWEEN ONSET AND DEATH</b><br><b>?</b><br><b>?</b> |                                  |  |   |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                                  |  |   |  |  |
| 19A. DATE OF OPERATION<br><b>0</b>   |                                  | 19B. MAJOR FINDINGS OF OPERATION   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <b>6/17/50</b> , 19 <b>50</b> , to <b>6/26/50</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>6/26/50</b> , and that death occurred at <b>12.45</b> p.m., from the causes and on the date stated above.   |                                  |  |   |  |  |
| 23A. SIGNATURE<br><b>Harry Deibel</b>  |                                  | 23B. ADDRESS<br><b>1226 Hanover St.</b>  |   | 23C. DATE SIGNED<br><b>6/27/50</b>                                       |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  |                                  | 24B. DATE<br><b>6/27/50</b>  |   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Salem</b>                       |  |
| 24D. LOCATION (City, town, or county)<br><b>Salem, Md.</b>   |                                  | 25. FUNERAL DIRECTOR<br><b>1219 St Paul St</b>   |   |  |  |

ATE RECEIVED BY  
LOCAL REGISTRAR  
JUN 27 1950

REGISTRAR'S SIGNATURE  
**Huntington Williams, M.D.**

ADDRESS  
**1219 St Paul St**  
**83a**

STATE OF NEW YORK  
DEPARTMENT OF CORRECTIONS

835  
A

Received of the  
Department of Corrections

the sum of \$100.00

for the year 1911

for the year 1912

Henry (Lester) Jones

1000 1st Ave. N.Y.C.

256  
50 5675BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5675

|   |                    |   |   |
|---|--------------------|---|---|
| BIRTH NO.   |                    | 2. DATE OF DEATH 6/26/50  |   |
| 1. NAME OF DECEASED (Type or Print) Mary Wagner   |                    | 2. DATE OF DEATH 6/26/50  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Md.<br>B. COUNTY 1-01 |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>Hosp. St. Gertrude's  |                    | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 1-01                          |   |
| C. Length of stay in Baltimore 45 Yrs. Mos. Days  |                    | D. STREET ADDRESS (If rural, give location)<br>1007 S. Potomac St. #4   |   |
| 5. SEX F  | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) M   | 8. DATE OF BIRTH AUG. 12-1890 .59           |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife  |                    | 9. AGE (In years last birthday) 59  |   |
| 10B. KIND OF BUSINESS OR INDUSTRY   |                    | 11. BIRTHPLACE (State or foreign country)<br>Poland.  |   |
| 13. FATHER'S NAME<br>HENRY KWASNIAK   |                    | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   |
| 14. MOTHER'S MAIDEN NAME<br>ON KWON   |                    | 17. INFORMANT ADDRESS<br>JOHN WAGNER 1007 S. POTOMAC ST.  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |                    | 16. SOCIAL SECURITY NO.   |   |
| 18. 260X I CAUSE OF DEATH   |                    |   |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>(A) ...<br>DUE TO |                    |   | INTERVAL BETWEEN ONSET AND DEATH<br>6-7 hrs |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B) ...<br>DUE TO   |                    |   | ?   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>N/A  |                    |   | ?   |
| 19A. DATE OF OPERATION 0  |                    | 19B. MAJOR FINDINGS OF OPERATION  |   |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                    |   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |                    | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                |   |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                    |   |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                    | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                  |   |
| 21F. HOW DID INJURY OCCUR?  |                    |   |   |
| 22. I hereby certify that I attended the deceased from 6:25, 1950, to 2:25, 1950 that I last saw the deceased alive on 6/25, 1950 and that death occurred at 2:25 m., from the causes and on the date stated above. |                    |   |   |
| 23A. SIGNATURE<br>William Williams, M.D.  |                    | 23B. ADDRESS<br>1000 S. Kenwood Ave   |   |
| 23C. DATE SIGNED<br>6/26/50   |                    |   |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   |                    | 24B. DATE<br>JUNE 30/50   |   |
| 24C. NAME OF CEMETERY OR CREMATORY<br>GERMAN HILL   |                    | 24D. LOCATION (City, town, or county) (State)<br>MD   |   |
| DATE RECEIVED BY LOCAL REGISTRAR<br>JUN 27 1950   |                    | REGISTRAR'S SIGNATURE<br>William Williams, M.D.   |   |
| 25. FUNERAL DIRECTOR<br>Stephen J. Fialkowski, Inc. 1000 S. KENWOOD AVE<br>Stephen J. Fialkowski  |                    | ADDRESS   |   |



1/25/20

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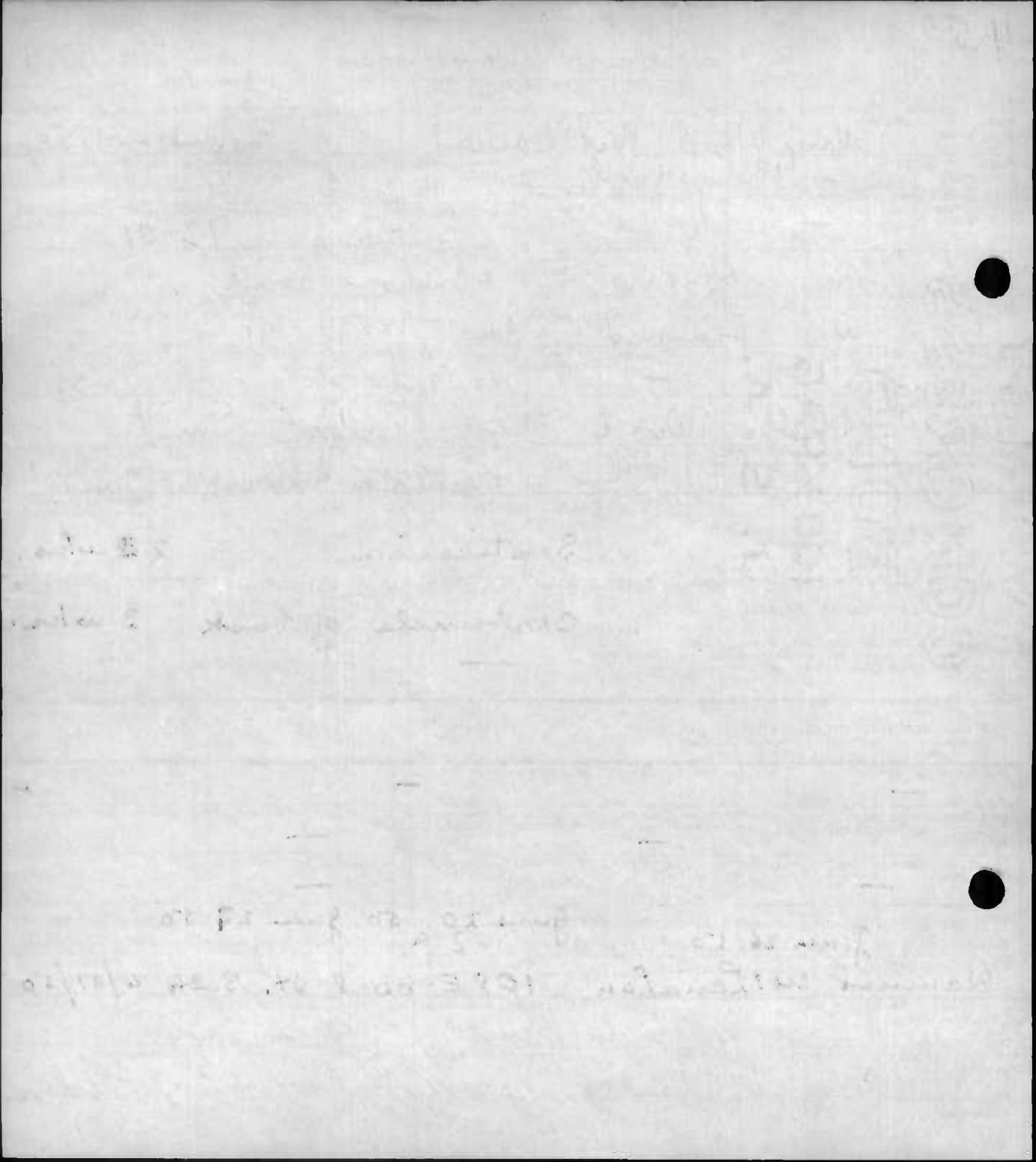
452  
0 5676

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5676

Registered No. \_\_\_\_\_

|  |                               |  |  |   |   |
|--|-------------------------------|--|--|---|---|
| BIRTH NO.  |                               | 1. NAME OF DECEASED<br>(Type or Print) <i>Mary Wood Williams</i>   |  | 2. DATE OF DEATH <i>June 27. 1950</i>   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>66 Bishops Road.</i>  |                               | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Maryland</i><br>B. COUNTY _____ |  |   |   |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br>—   |                               | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 12-01</i>                               |  |   |   |
| 6. Length of stay in Baltimore <i>64 years</i>   |                               | D. STREET ADDRESS (If rural, give location)<br><i>66 Bishops Road.</i>   |  |   |   |
| 7. SEX<br><i>F</i>   | 8. COLOR OR RACE<br><i>W.</i> | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Widowed</i>  | 10. DATE OF BIRTH<br><i>June 5, 1859</i> | 11. AGE (In years last birthday)<br><i>91</i>                                       | 12. If Under 1 Year: Months: Days<br>If Under 24 Hours: Hours: Min. |
| 13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>housewife</i>   |                               | 14. KIND OF BUSINESS OR INDUSTRY<br>—  |  | 15. BIRTHPLACE (State or foreign country)<br><i>New York State</i>                  |   |
| 16. FATHER'S NAME<br><i>Daniel Phelps Wood</i>   |                               | 17. MOTHER'S MAIDEN NAME<br><i>Lora Celeste Smith</i>  |  | 18. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>   |   |
| 19. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><i>no</i>   |                               | 20. SOCIAL SECURITY NO.<br>—   |  | 21. INFORMANT ADDRESS<br><i>Huntington Williams, 720 W. Belvedere Ave.</i>          |   |
| 18. 053.4 I CAUSE OF DEATH   |                               |  |  |   |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  |                               |  |  |   |   |
| (A) <i>Septicemia</i> 2 wks.   |                               |  |  |   |   |
| DUE TO   |                               |  |  |   |   |
| ANTECEDENT CAUSES  |                               |  |  |   |   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |                               |  |  |   |   |
| (B) <i>Carbuncle of back</i> 3 wks.  |                               |  |  |   |   |
| DUE TO   |                               |  |  |   |   |
| (C) —  |                               |  |  |   |   |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                               |  |  |   |   |
| 19A. DATE OF OPERATION <i>0</i>  |                               | 19B. MAJOR FINDINGS OF OPERATION<br>—  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                               | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br>—                                       |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>—       |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY<br>—   |                               | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK                               |  | 21F. HOW DID INJURY OCCUR?<br>—   |   |
| 22. I hereby certify that I attended the deceased from <i>June 20, 1950</i> to <i>June 27, 1950</i> that I last saw the deceased alive on <i>June 26, 1950</i> and that death occurred at <i>2 a. m.</i> , from the causes and on the date stated above. |                               |  |  |   |   |
| 23A. SIGNATURE<br><i>Daniel W. Lanahan</i>   |                               | 23B. ADDRESS<br><i>108 E. 33rd St. Balto</i>   |  | 23C. DATE SIGNED<br><i>6/27/50</i>  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                               | 24B. DATE<br><i>June 29, 1950</i>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Green Mount</i>                            |   |
| 24D. LOCATION (City, town, or county) (State)<br><i>Balto, Md</i>  |                               | 25. FUNERAL DIRECTOR<br><i>Henry M. Jenkins</i>  |  | ADDRESS<br><i>Sm Co 4905 York Rd</i>  |   |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUN 27 1950</i>   |                               | REGISTRAR'S SIGNATURE<br><i>Huntington Williams, M.D.</i>  |  | 25. FUNERAL DIRECTOR<br><i>Henry M. Jenkins</i>                                     |   |



252  
50 5677BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5677  
Registered No.

BIRTH NO.

|   |                           |  |                                      |
|---|---------------------------|--|--------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>William J. Moesinger</b>  |                           | 2. DATE OF DEATH <b>June 26 1950</b>   |                                      |
| 3. PLACE OF DEATH:<br><b>Baltimore City, Maryland</b>   |                           | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY |                                      |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>1607 Normal Ave</b>   |                           | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 8-05</b>                  |                                      |
| 6. Length of stay in Baltimore<br><b>60</b> Yrs. Mos. Days  |                           | D. STREET ADDRESS (If rural, give location)<br><b>1607 Normal Ave</b>  |                                      |
| 7. SEX <b>M</b>   | 8. COLOR OR RACE <b>W</b> | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>  | 10. DATE OF BIRTH <b>July 5-1884</b> |
| 11. USUAL OCCUPATION (Give kind of work during most of working life, even if retired)<br><b>Silversmith</b>   |                           | 12. AGE (in years last birthday) <b>65</b> Months: Days: Hours: Min.   |                                      |
| 13. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>  |                           | 14. BIRTHPLACE (State or foreign country)<br><b>New York NY</b>  |                                      |
| 15. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                           | 16. MOTHER'S MAIDEN NAME<br><b>Margaret Hempel</b>   |                                      |
| 17. FATHER'S NAME<br><b>Henry Moesinger</b>   |                           | 18. MOTHER'S MAIDEN NAME<br><b>Margaret Hempel</b>   |                                      |
| 19. WAS DECEASED EVER IN U. S. ARMED FORCES (If yes, give war or dates of service)  |                           | 20. SOCIAL SECURITY NO.  |                                      |
| 21. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Pulmonary T. B.</b><br>DUE TO<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Myocardial Infarction</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>None</b> |                           | 22. INTERVAL BETWEEN ONSET AND DEATH<br><b>3 months</b><br><b>3 day</b>  |                                      |
| 23. DATE OF OPERATION<br><b>None</b>  |                           | 24. MAJOR FINDINGS OF OPERATION  |                                      |
| 25. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                           |  |                                      |
| 26. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                           | 27. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                               |                                      |
| 28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                           |  |                                      |
| 29. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                           | 30. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                  |                                      |
| 31. HOW DID INJURY OCCUR?   |                           |  |                                      |
| 32. I hereby certify that I attended the deceased from <b>6/23</b> , 19 <b>50</b> , to <b>6/26</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>6/26</b> , 19 <b>50</b> , and that death occurred at <b>11:34</b> a. m., from the causes and on the date stated above.   |                           |  |                                      |
| 33. SIGNATURE<br><b>Samuel M. Miller</b>  |                           | 34. ADDRESS<br><b>4500 Harford Rd</b>  |                                      |
| 35. DATE SIGNED<br><b>6/26/50</b>   |                           |  |                                      |
| 36. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                           | 37. DATE<br><b>June 28/50</b>  |                                      |
| 38. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore</b>   |                           | 39. LOCATION (City, town, or county) (State)<br><b>Baltimore Md</b>  |                                      |
| 40. DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 27 1950</b>  |                           | 41. REGISTRAR'S SIGNATURE<br><b>Henry M. Williams</b>  |                                      |
| 42. FUNERAL DIRECTOR<br><b>Henry M. Williams</b>  |                           | 43. ADDRESS<br><b>4905 York Rd</b>   |                                      |

VS 150

32032

13B

Mr. D. Miller  
4510 Hayford Rd.

432

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 5678BIRTH NO. 5678

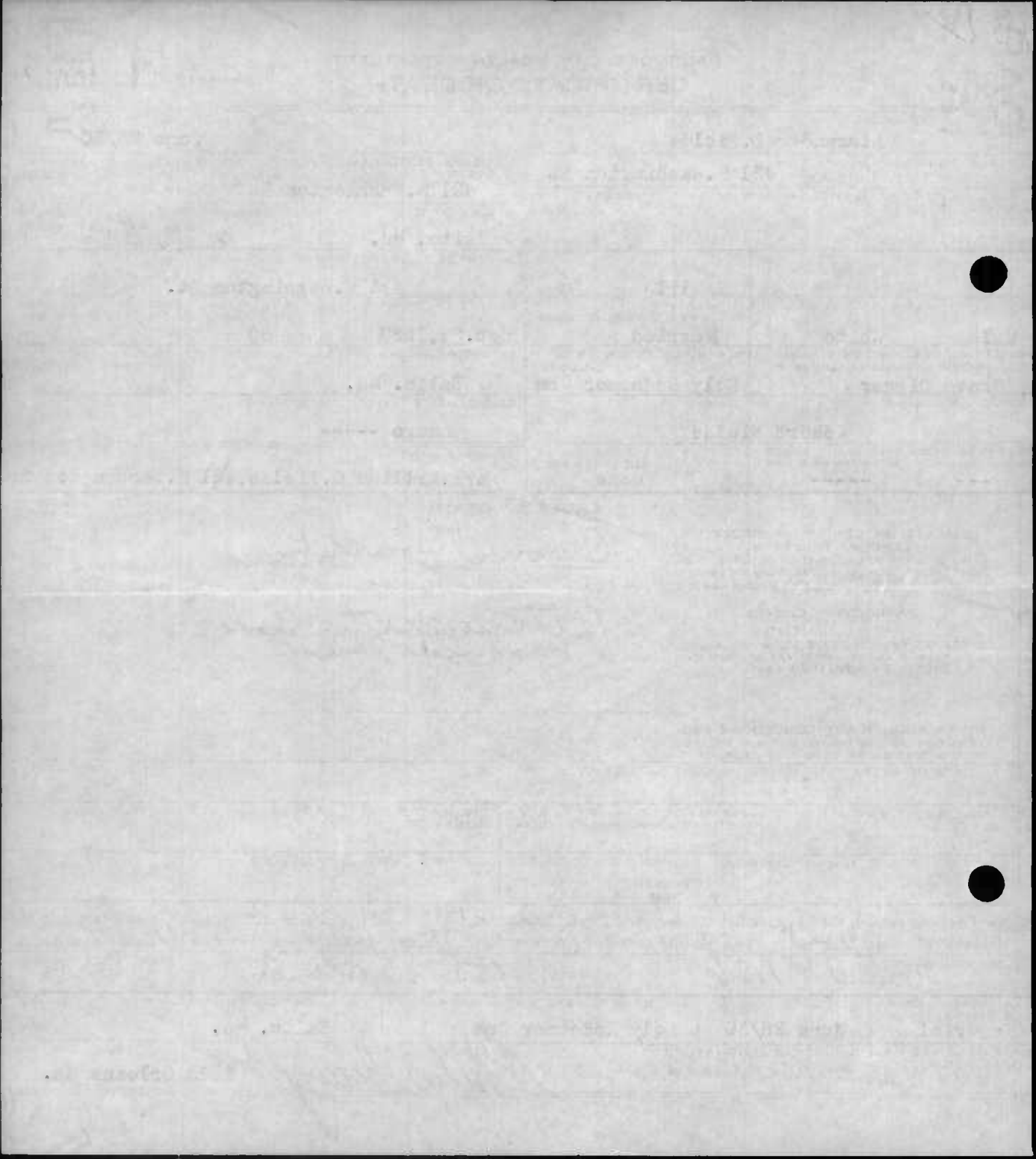
|   |                                  |   |  |  |  |
|---|----------------------------------|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Alexander H. Fields</b>   |                                  |   | 2. DATE OF DEATH<br><b>June 26/50</b>  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>421 N. Washington St</b>                                       |                                  |   | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <b>421 N. Washington St</b><br>B. COUNTY |  |  |
| 5. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>421 N. Washington St</b> |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Balto. Md.</b>  |  |  |
| 6. Length of stay in Baltimore <b>life</b>  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>421 N. Washington St.</b>  |  |  |
| 7. SEX<br><b>Male</b>   | 8. COLOR OR RACE<br><b>White</b> | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b> | 10. DATE OF BIRTH<br><b>Oct. 25, 1889</b>  |  | 11. AGE (In years, last birthday)<br><b>60</b>                 |
| 12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Grave Digger</b>   |                                  |   | 13. KIND OF BUSINESS OR INDUSTRY<br><b>Holy Redeemer Cem</b>   |  | 14. BIRTHPLACE (State or foreign country)<br><b>Balto. Md.</b> |
| 15. FATHER'S NAME<br><b>Robert Fields</b>   |                                  |   | 16. MOTHER'S MAIDEN NAME<br><b>Laura -----</b>   |  |  |
| 17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>----</b>                  |                                  |   | 18. SOCIAL SECURITY NO.<br><b>none</b>   |  |  |
| 19. INFORMANT<br><b>Mrs. Lillian C. Fields</b>  |                                  |   | 20. ADDRESS<br><b>421 N. Washington St.</b>  |  |  |

|  |   |  |  |  |  |
|--|---|--|--|--|--|
| 18. <b>422.1</b>   |   | CAUSE OF DEATH   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  |   | (A) <b>Chronic Myocarditis</b>   |  |  |  |
| ANTECEDENT CAUSES  |   | DUE TO   |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |   | (B) <b>Arteriosclerotic Cardio-vascular Disease</b>                      |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |   | (C) -----  |  |  |  |
| 19A. DATE OF OPERATION<br><b>0</b>   |   | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour)  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I hereby certify that I attended the deceased from <b>June 18, 1950</b> , to <b>June 26, 1950</b> , that I last saw the deceased alive on <b>June 26, 1950</b> , and that death occurred at <b>7:30 A.M.</b> , from the causes and on the date stated above. |   |  |  |  |  |
| 23A. SIGNATURE<br><b>General B. White</b>  |   | 23B. ADDRESS<br><b>1331 North Ave</b>                                    |  | 23C. DATE SIGNED<br><b>6-27-50</b>                                       |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 24B. DATE<br><b>June 28/50</b>  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cem</b>           | 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b> |  |  |
| DATE RECEIVED BY<br><b>JUN 27 1950</b>   |   | REGISTRAR'S SIGNATURE<br><b>Wilmington Williams, M.D.</b>                |  | FUNERAL DIRECTOR<br><b>Philip Henry Jones</b>                            |  |
| VS 150   |   | ADDRESS<br><b>2024 Orleans St.</b>                                       |  |  |  |

98881

93D





520  
50 5679BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5679  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

|   |                               |  |  |  |   |  |  |
|---|-------------------------------|--|--|--|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Margaret M. Long</i>  |                               |  |  | 2. DATE OF DEATH <i>June 25, 1950</i>  |   |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>426 Winston Ave</i>  |                               |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>md</i> B. COUNTY <i>Baltimore</i> |   |  |  |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION   |                               |  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore</i> <i>27-11</i>                          |   |  |  |
| C. Length of stay in Baltimore <i>9 yrs</i>   |                               |  |  | D. STREET ADDRESS (If rural, give location)<br><i>426 Winston Ave</i>  |   |  |  |
| 5. SEX<br><i>F</i>  | 6. COLOR OR RACE<br><i>W.</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Mar.</i> |  | 8. DATE OF BIRTH<br><i>Aug 15, 1900</i>  | 9. AGE (In years, last birthday)<br><i>49</i> | If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min. |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i> |                               | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Home</i>               |  | 11. BIRTHPLACE (State or foreign country)<br><i>Fairmont W. Va</i>   |   | 12. CITIZEN OF WHAT COUNTRY?                                 |  |
| 13. FATHER'S NAME<br><i>Howard Adams</i>  |                               |  |  | 14. MOTHER'S MAIDEN NAME<br><i>Nora Summers</i>  |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)        |                               |  |  | 16. SOCIAL SECURITY NO.  |   |  |  |
|   |                               |  |  | 17. INFORMANT ADDRESS<br><i>Arthur L. Long 426 Winston Ave</i>   |   |  |  |

|  |  |  |
|--|--|--|
| 18. <i>581.0</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | CAUSE OF DEATH<br>(A) <i>Pulmonary Hemorrhage</i><br>DUE TO<br>(B) <i>Cirrhosis Liver</i><br>DUE TO<br>(C) _____ | INTERVAL BETWEEN ONSET AND DEATH<br><i>6 hrs</i><br><i>1 yr.</i> |
|--|--|--|

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 19A. DATE OF OPERATION <i>0</i>   |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME (Month) (Day) (Year) (Hour) <i>0</i>  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <i>Jan 18, 1950</i> , to <i>June 25, 1950</i> , that I last saw the deceased alive on <i>June 25, 1950</i> , and that death occurred at <i>6:20 p.m.</i> , from the causes and on the date stated above. |  |   |  |  |  |
| 23A. SIGNATURE<br><i>Carl H. Benson, M.D.</i>   |  | 23B. ADDRESS  |  | 23C. DATE SIGNED   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  | 24B. DATE<br><i>June 28/50</i>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Druid Ridge</i>                 |  |
| 24D. LOCATION (City, town, or county)<br><i>Baltimore</i>   |  | 24E. STATE<br><i>Md</i>   |  | 24F. FUNERAL DIRECTOR<br><i>Long Myers</i>                               |  |
| 24G. DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUN 27 1950</i>   |  | 24H. REGISTRAR'S SIGNATURE<br><i>Wilmington Williams, M.D.</i>  |  | 24I. ADDRESS<br><i>5005 Pl. Hyattsville</i>                              |  |

WALTER  
CONGRES  
BOND

120  
0 5680BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

Dr. Higgins  
50 5680

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

NINA GOMER DuBOIS

2. DATE  
OF  
DEATH

June 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

2417 Pulaski Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)

2417 Pulaski Street

E. Length of stay in Baltimore

10 yrs.

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

Female Colored

Married

July 4, 1872

77

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Quincy, Ill.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles Gomer

14. MOTHER'S MAIDEN NAME

Mary Scheider

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Dr. W.E.B. DuBois 409 Edgcombe Ave.

New York, N.Y.

18. 332X I

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Cerebral Embolism

1 day.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Generalized Arteriosclerosis

2 years

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Cerebral Sclerosis

6 months

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 29, 1950, to June 26, 1950, that I last saw the deceased alive on June 26, 1950, and that death occurred at 8:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

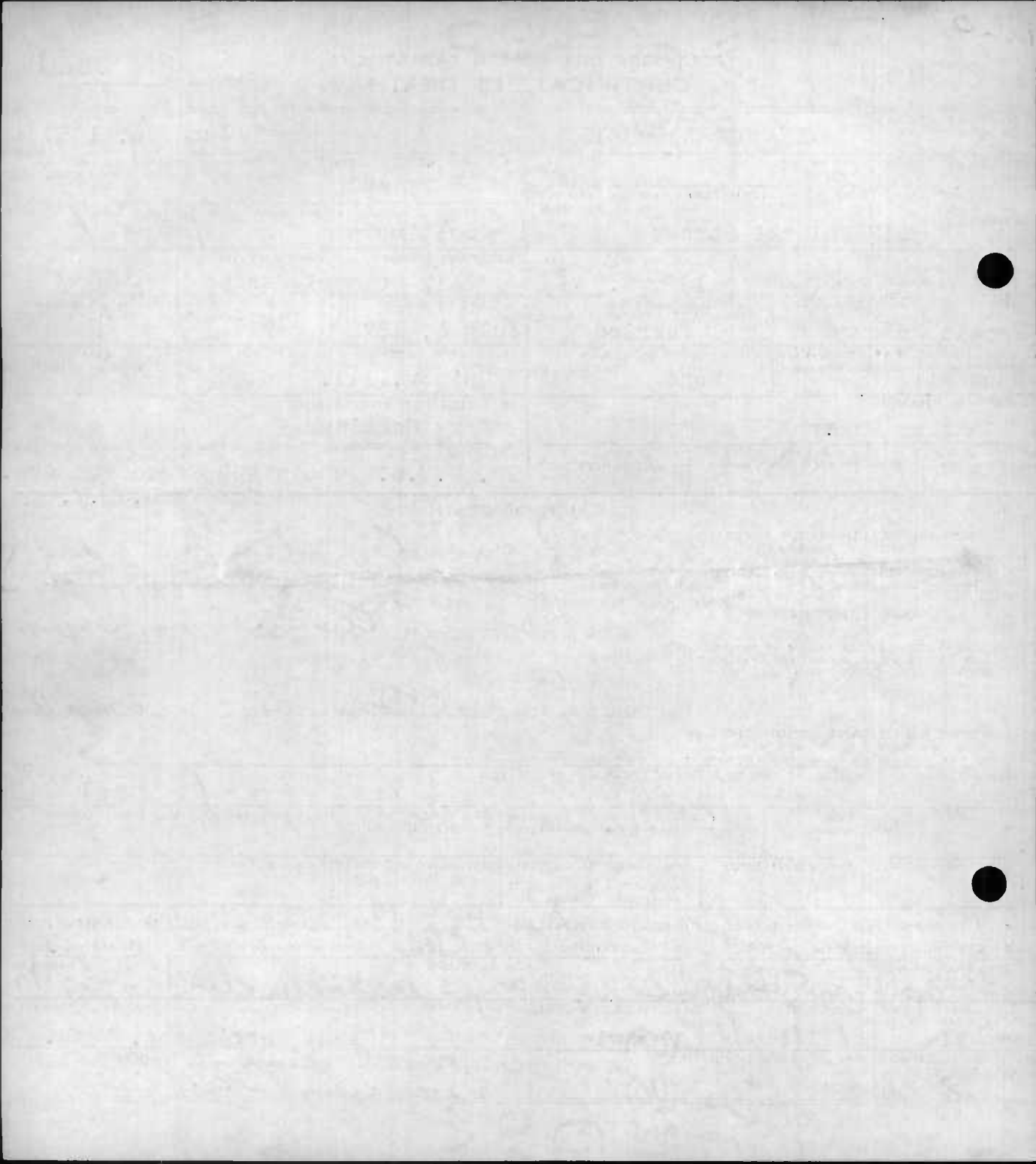
25. FUNERAL DIRECTOR

ADDRESS

June 28 1950

Frederick W. Williams, M.D.

Funeral Home  
1651 David Hill Ave.



630  
0 5681BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5681

|   |                           |  |                                  |   |   |
|---|---------------------------|--|----------------------------------|---|---|
| BIRTH NO.   |                           | 1. NAME OF DECEASED<br>(Type or Print) Edward E. Ford  |                                  | 2. DATE OF DEATH June 26, 1950  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                           | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY |                                  |   |   |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br>3524 Elm Avenue  |                           | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 8-07                       |                                  |   |   |
| 6. Length of stay in Baltimore 12   |                           | D. STREET ADDRESS (If rural, give location)<br>1219 Rutland Ave.   |                                  |   |   |
| 7. SEX<br>Male  | 8. COLOR OR RACE<br>White | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Divorced  | 10. DATE OF BIRTH<br>Oct 19-1893 | 11. AGE (in years last birthday)<br>56  | 12. Under 1 Year Months Days<br>13. Under 24 Hours Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Welder   |                           | 10B. KIND OF BUSINESS OR INDUSTRY<br>Glenn Martin Co.  |                                  | 11. BIRTHPLACE (State or foreign country)<br>New York                               |   |
| 12. CITIZEN OF WHAT COUNTRY?<br>USA   |                           | 13. FATHER'S NAME<br>Stephen A. Ford   |                                  |   |   |
| 14. MOTHER'S MAIDEN NAME<br>Matilda Plante  |                           | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(If yes, give war or dates of service)<br>No                         |                                  |   |   |
| 16. SOCIAL SECURITY NO.<br>285-10-7866  |                           | 17. INFORMANT ADDRESS<br>Miss Nellie Woodward 3524 Elm Ave Balto Md  |                                  |   |   |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>INTERVAL BETWEEN ONSET AND DEATH<br>2 hours.<br>(A) Acute Cordic Spleton<br>DUE TO<br>(B) Cholecyctitis Cholelithiasis<br>DUE TO<br>(C) 8 days<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>Unknown |                           |  |                                  |   |   |
| 19A. DATE OF OPERATION<br>no 0  |                           | 19B. MAJOR FINDINGS OF OPERATION<br>one  |                                  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21A. ACCIDENT WAS UNDER- Lying <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                           | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                            |                                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                           | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK               |                                  | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I hereby certify that I attended the deceased from June 18, 1950, to June 26, 1950, that I last saw the deceased alive on July 7, 1950, and that death occurred at 10:00 a.m., from the causes and on the date stated above.  |                           |  |                                  |   |   |
| 23A. SIGNATURE<br>R. A. Felleich  |                           | 23B. ADDRESS<br>3524 Elm Ave   |                                  | 23C. DATE SIGNED<br>6/27/1950   |   |
| 24A. BURIAL, CREMA- TION, REMOVAL (Specify)<br>Removal & Burial   |                           | 24B. DATE<br>June 27, 50   |                                  | 24C. NAME OF CEMETERY OR CREMATORY<br>Falls Cemetery                                |   |
| 24D. LOCATION (City, town, or county)<br>Greece, New York   |                           | 25. FUNERAL DIRECTOR<br>Burgee Funeral Home 3631 Falls Road  |                                  |   |   |



What was the first time  
that you saw the first time

the first time

for the first time  
the first time

the first time  
the first time

560  
50 5682

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5682

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

|   |                       |  |  |  |  |
|---|-----------------------|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) JANE ANN TONER   |                       |  | 2. DATE OF DEATH<br>JUNE 26, 1950  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                       |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE Maryland B. COUNTY _____ |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION University Hospital |                       |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 4-02                             |  |  |
| C. Length of stay in Baltimore  |                       |  | D. STREET ADDRESS (If rural, give location)<br>629 W. Baltimore St.  |  |  |
| 5. SEX<br>F   | 6. COLOR OR RACE<br>W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Widowed | 8. DATE OF BIRTH<br>July 1, 1870   |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife                            |                       |  | 9. AGE (In years last birthday) 79   |  |  |
| 10B. KIND OF BUSINESS OR INDUSTRY<br>Home   |                       |  | 11. BIRTHPLACE (State or foreign country)  |  |  |
| 13. FATHER'S NAME<br>Frederick Ives   |                       |  | 12. CITIZEN OF WHAT COUNTRY?   |  |  |
| 14. MOTHER'S MAIDEN NAME<br>Jane  |                       |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>Yes, no or unknown (If yes, give war or dates of service)                  |  |  |
| 16. SOCIAL SECURITY NO.   |                       |  | 17. INFORMANT<br>George Smitherman, Ivy Hill   |  |  |
| 18. 443X E 903.0  |                       |  | ADDRESS  |  |  |

|  |  |                                  |
|--|--|----------------------------------|
| 18. 443X E 903.0 CAUSE OF DEATH  |  | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>(A) Hypertensive Cardiovascular Disease<br>DUE TO |  |                                  |
| ANTECEDENT CAUSES<br>(B) _____<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(C) _____   |  |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>Fracture, greater tubercle, left humerus  |  |                                  |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 19A. DATE OF OPERATION   |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br>Home                    |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>629 W. Baltimore St. |  |
| 21D. TIME (Month) (Day) (Year) (Hour) of INJURY<br>June 12, 1950 a. m.   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?<br>Deck chair collapsed and deceased fell to floor                    |  |
| 22. I certify that I took charge of the remains described above, held an Inspection & Ing. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |  |  |  |  |  |
| 23A. SIGNATURE<br>Stanley H. Dureacher M.D.  |  | 23B. CHIEF MEDICAL EXAMINER.....<br>ASSISTANT MEDICAL EXAMINER.....  |  | 23C. DATE SIGNED<br>June 27, 1950  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  |  | 24B. DATE<br>June 29/50  |  | 24C. NAME OF CEMETERY OR CREMATORY<br>Ivy Hill   |  |
| 24D. LOCATION (City, town, or county) (State)<br>Baltimore Md.   |  | 24E. FUNERAL DIRECTOR<br>Wm. W. Brown  |  | 24F. ADDRESS<br>Lanus Md. 93D  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br>JUN 28 1950  |  | REGISTRAR'S SIGNATURE<br>Trusting M. Williams, M.D.  |  | 25. FUNERAL DIRECTOR<br>Wm. W. Brown   |  |



460  
0 5683BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5683  
Registered No.

|   |   |  |   |
|---|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Austin Joseph Miller</b>  |   | 2. DATE OF DEATH<br><b>June 25, 1950</b>   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>2115 Penrose Ave</b>  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTIMORE 20-02</b>                         |   |
| c. Length of stay in Baltimore<br><b>41</b> Yrs. <del>Mo.</del> <del>Days</del>   |   | D. STREET ADDRESS (If rural, give location)<br><b>2115 Penrose Ave</b>   |   |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>MARRIED</b>  | 8. DATE OF BIRTH<br><b>April 3, 1884</b>                          |
| 9. AGE (In years last birthday)<br><b>61</b>  |   | 10. Under 1 Year: Months <b>—</b> Days <b>—</b><br>10. Under 24 Hours: Hours <b>—</b> Min. <b>—</b>                            |   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RAILROAD Conductor</b>  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>TRANSPORTATION</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>HARMAN Miller</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>MARY HOOD</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |   | 16. SOCIAL SECURITY NO.<br><b>705-12-3715</b>  |   |
| 17. INFORMANT<br><b>MRS ANNA MILLER</b>   |   | ADDRESS<br><b>2115 Penrose</b>   |   |
| 18. <b>002X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br><b>Tuberculosis, pulmonary 5 years</b><br>DUE TO |   | INTERVAL BETWEEN ONSET AND DEATH   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>CHRONIC MYOCARDITIS</b><br>DUE TO  |   |  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |   |  |   |
| 19A. DATE OF OPERATION<br><b>0</b>  |   | 19B. MAJOR FINDINGS OF OPERATION   |   |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |   |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |   |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <b>March 1, 1950</b> , to <b>June 25, 1950</b> , that I last saw the deceased alive on <b>June 24, 1950</b> , and that death occurred at <b>12:34 a.m.</b> , from the causes and on the date stated above.                                 |   |  |   |
| 23A. SIGNATURE<br><b>Melvin N. Borden</b>   |   | 23B. ADDRESS<br><b>2030 W. Fayette St</b>  |   |
| 23C. DATE SIGNED<br><b>6/26/50</b>  |   |  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   | 24B. DATE<br><b>6-28-50</b>   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Cathedral</b>   | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore</b> |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 28 1950</b>  | REGISTRAR'S SIGNATURE<br><b>Wilmington Williams, M.D.</b>   | 25. FUNERAL DIRECTOR<br><b>George Bailey Int'l Burial &amp; Crematory</b>  |   |
| VS 150  |   | ADDRESS  |   |

MEDICAL CERTIFICATION

10247

1363



536  
50 5684BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5684

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mary F. Schneider

2. DATE  
OF DEATH June 25th., 19503. PLACE OF DEATH:  
A. Baltimore City, MarylandB. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE 1027 E. Biddle Street4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE MarylandC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 10-01c. Length of stay in Baltimore Life  
Yrs. Mos. DaysD. STREET ADDRESS (If rural, give location)  
1027 E. Biddle Street5. SEX  
Female6. COLOR OR RACE  
White7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
Married8. DATE OF BIRTH  
Aug. 9th., 18639. AGE (In years last birthday) 86  
H Under 1 Year Months: Days I0 I6  
H Under 24 Hours Hours: Min.10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
Housewife10B. KIND OF BUSINESS OR INDUSTRY  
Own Home11. BIRTHPLACE (State or foreign country)  
Baltimore, Maryland12. CITIZEN OF WHAT COUNTRY?  
U.S.A.13. FATHER'S NAME  
Joseph Etzel14. MOTHER'S MAIDEN NAME  
Minnie (Wilhelmina) Stenger15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, oo or unknown) (If yes, give war or dates of service)  
No None16. SOCIAL SECURITY NO.  
None17. INFORMANT ADDRESS  
Mr. William A. Schneider--1027 E. Biddle St

18. CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  
Chronic myocarditis + myocardial degeneration

(A) DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION 0 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 3, 1942, to June 25, 1950, that I last saw the deceased alive on June 25, 1950, and that death occurred at 7:15 pm., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

George J. Ruth, Inc. - 1735 Harford Avenue

JUN 28 1950  
VS 150

937





20 50 5685

JL- 128356

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5685

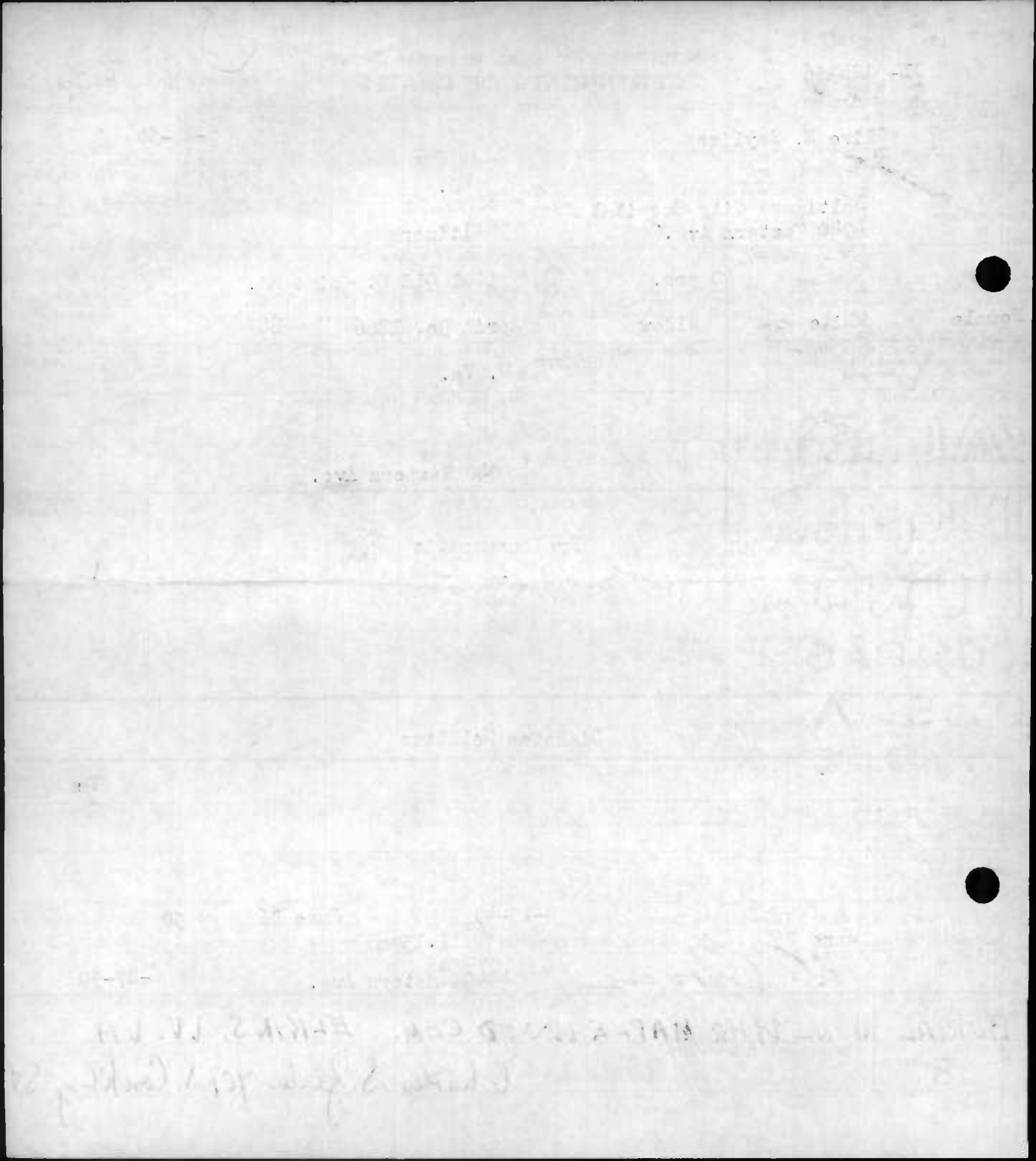
BIRTH NO.

|   |                                  |   |  |   |   |
|---|----------------------------------|---|--|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Olive E. Bayliss</b>  |                                  |   | 2. DATE OF DEATH <b>6-26-50</b>  |   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b><br>B. COUNTY <b>Baltimore</b> |   |   |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Baltimore City Hospital</b><br><b>4940 Eastern Ave.</b> |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b><br><b>Dundalk</b>                         |   |   |
| 6. Length of stay in Baltimore <b>40 yrs.</b>   |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>1101 Old N. Point Rd.</b><br><b>5300</b>   |   |   |
| 7. SEX<br><b>Female</b>   | 8. COLOR OR RACE<br><b>White</b> | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widow</b> | 10. DATE OF BIRTH<br><b>April 30, 1866</b>   | 11. AGE (In years last birthday)<br><b>84</b> | 12. If Under 1 Year Months: Days<br>If Under 24 Hours Hours: Min. |
| 13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)            |                                  |   | 14. BIRTHPLACE (State or foreign country)<br><b>W. Va.</b>   |   |   |
| 15. FATHER'S NAME<br><b>?</b>   |                                  |   | 16. CITIZEN OF WHAT COUNTRY?   |   |   |
| 17. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(If yes, give war or dates of service)                |                                  |   | 18. SOCIAL SECURITY NO.  |   |   |
| 19. INFORMANT ADDRESS<br><b>4940 Eastern Ave.</b>   |                                  |   |  |   |   |

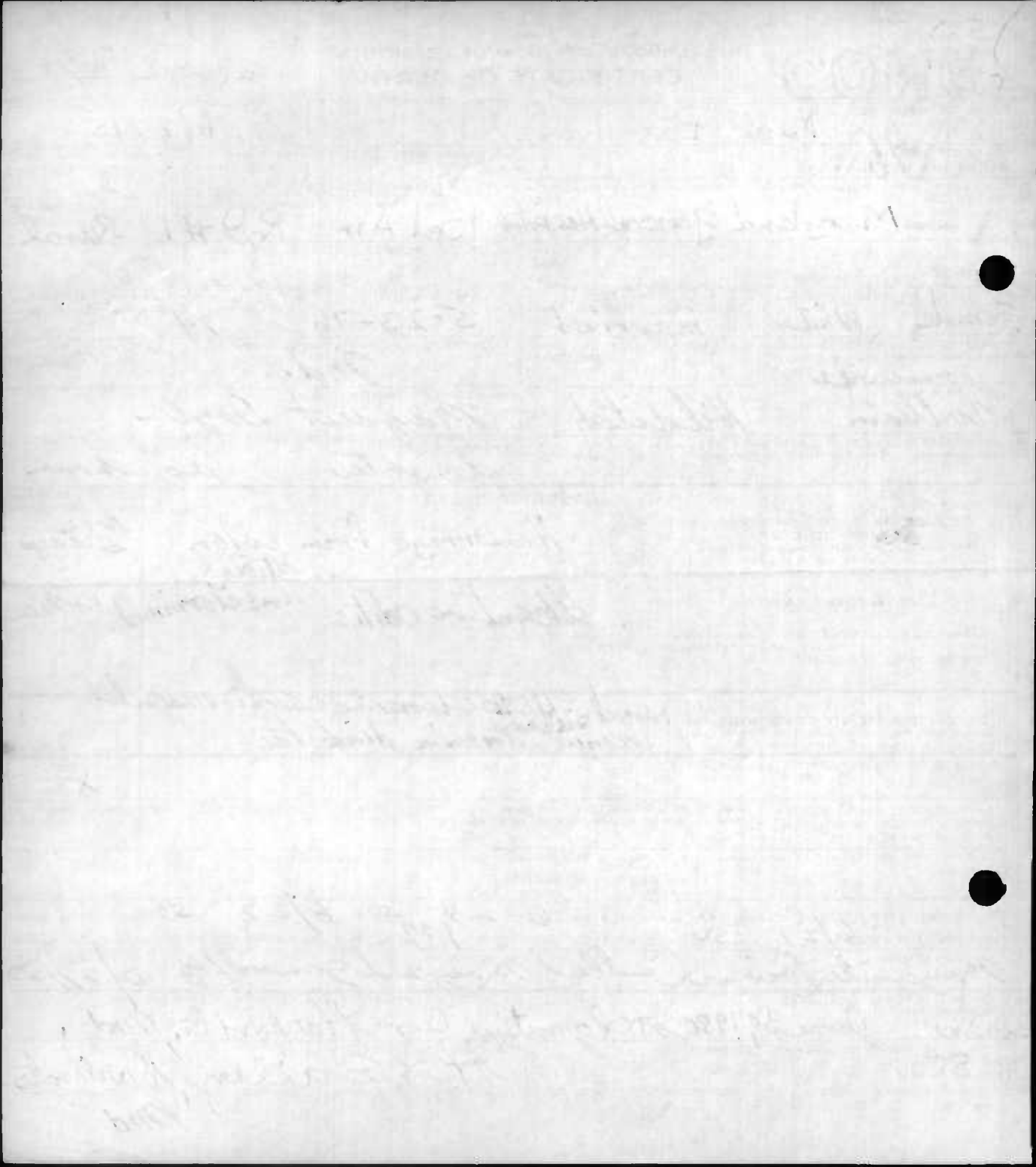
|  |                                  |
|--|----------------------------------|
| 18. <b>600.0</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Pylonephritis</b><br>DUE TO<br>(A) .....<br>(B) .....<br>(C) .....<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(A) .....<br>(B) .....<br>(C) .....<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>Diabetes Mellitus</b> | INTERVAL BETWEEN ONSET AND DEATH |
|--|----------------------------------|

|   |  |  |  |   |
|---|--|--|--|---|
| 19A. DATE OF OPERATION <b>2</b>   |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  | 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |   |
| 22. I hereby certify that I attended the deceased from <b>4-19-49</b> , 19 <b>50</b> , to <b>June 26</b> , 19 <b>50</b> that I last saw the deceased alive on <b>June 26</b> , 19 <b>50</b> and that death occurred at <b>11.15pm</b> from the causes and on the date stated above. |  |  |  |   |
| 23A. SIGNATURE<br><b>W. J. O'Brien</b>  |  | 23B. ADDRESS<br><b>4940 Eastern Ave.</b>                                 |  | 23C. DATE SIGNED<br><b>6-27-50</b>  |

|   |   |  |  |
|---|---|--|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 24B. DATE<br><b>JUNE 29, 1950</b>                             | 24C. NAME OF CEMETERY OR CREMATORY<br><b>MAPLE WOOD CEM.</b> | 24D. LOCATION (City, town, or county) (State)<br><b>ELKINS, W. VA.</b> |
| 25. STATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 28 1950</b> | 26. REGISTRAR'S SIGNATURE<br><b>Wilmington Williams, M.D.</b> | 27. FUNERAL DIRECTOR<br><b>Charles S. Fisher</b>             | 28. ADDRESS<br><b>901 S. Conkling St</b>                               |



| 655<br>50 5686   |                                  | BOARMAN<br>BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH   |                                    | X<br>Registered No. 50 5686   |                              |
|--|----------------------------------|---|------------------------------------|---|------------------------------|
| BIRTH NO.  |                                  | 1. NAME OF DECEASED<br>(Type or Print) <i>Mary Boarman</i>  |                                    | 2. DATE OF DEATH <i>6/27/50</i>   |                              |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>Harford</i>  |                                    |   |                              |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><i>Maryland General Hospital</i>   |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Bel Air RD #1 Rural</i>  |                                    |   |                              |
| C. Length of stay in Baltimore<br>Yrs. Mos. Days   |                                  | D. STREET ADDRESS (If rural, give location)<br><i>6200</i>  |                                    |   |                              |
| 5. SEX<br><i>Female</i>  | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>married</i>   | 8. DATE OF BIRTH<br><i>5-23-76</i> | 9. AGE (In years last birthday)<br><i>74</i>  | 10. Under 1 Year Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>housewife</i>  |                                  | 10B. KIND OF BUSINESS OR INDUSTRY   |                                    | 11. BIRTHPLACE (State or foreign country)<br><i>Md.</i>                             |                              |
| 13. FATHER'S NAME<br><i>William</i>  |                                  | 14. MOTHER'S MAIDEN NAME<br><i>Margaret Doyle</i>   |                                    | 12. CITIZEN OF WHAT COUNTRY?  |                              |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.   |                                    | 17. INFORMANT<br><i>daughter</i> ADDRESS<br><i>as above</i>                         |                              |
| 18. <i>260X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                           |                                  | CAUSE OF DEATH<br>(A) <i>Hemorrhage from colon</i><br>DUE TO<br>(B) <i>Ulcerative colitis</i><br>DUE TO<br>(C) <i>etiology undetermined</i>   |                                    | INTERVAL BETWEEN ONSET AND DEATH<br><i>over 5 days</i>                              |                              |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |                                  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><i>renal disease, hypertension, cardiovascular, uremia, anemia, diabetes</i> |                                    |   |                              |
| 19A. DATE OF OPERATION   |                                  | 19B. MAJOR FINDINGS OF OPERATION  |                                    | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                              |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |                              |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                  | 21E. INJURY OCCURRED<br>m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                                    | 21F. HOW DID INJURY OCCUR?  |                              |
| 22. I hereby certify that I attended the deceased from <i>6-24-1950</i> to <i>6/27-1950</i> , that I last saw the deceased alive on <i>6/27-1950</i> and that death occurred at <i>127</i> m., from the causes and on the date stated above. |                                  |   |                                    |   |                              |
| 23a. SIGNATURE<br><i>Mary Louise Cadell</i>  |                                  | 23b. ADDRESS<br><i>Maryland General Hospital</i>  |                                    | 23c. DATE SIGNED<br><i>6/27/50</i>  |                              |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Buried</i>   |                                  | 24B. DATE<br><i>June 30, 1950</i>   |                                    | 24C. NAME OF CEMETERY OR CREMATORY<br><i>St Ignatius Ann</i>                        |                              |
| 24D. LOCATION (City, town, or county)<br><i>Harford Co, Md</i>   |                                  | 24E. REGISTRAR'S SIGNATURE<br><i>Wilmington, Delaware, Md</i>   |                                    | 25. FUNERAL DIRECTOR<br><i>H. S. Bailey, Wilmington, Md</i>                         |                              |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUN 28 1950</i>   |                                  | ADDRESS<br><i>Wilmington, Md</i>  |                                    |   |                              |



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5687  
Registered No.

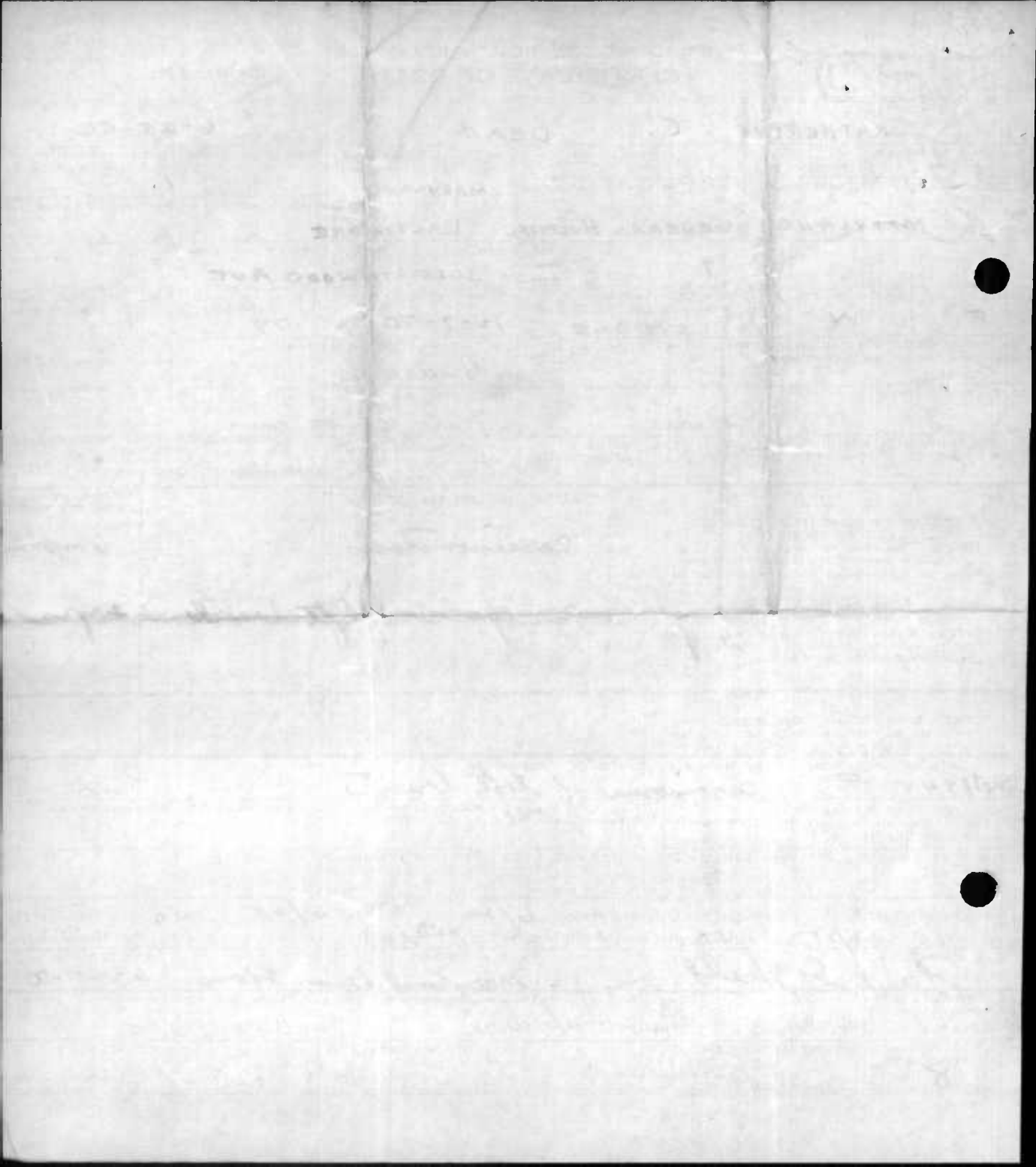
BIRTH NO.

|  |                           |  |   |
|--|---------------------------|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>KATHERINE C. DEAN</b>  |                           | 2. DATE OF DEATH <b>6-25-50</b>  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland ✓  |                           | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b> |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>MARYLAND GENERAL HOSPITAL BALTIMORE</b> |                           | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Parkville</b>   |   |
| C. Birth of stay in Baltimore <b>9</b> Yrs. <b>Dec.</b> Days <b>Dec.</b>   |                           | D. STREET ADDRESS (If rural, give location)<br><b>3015 LINWOOD AVE 5300</b>  |   |
| 5. SEX <b>F</b>  | 6. COLOR OR RACE <b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>SINGLE</b>   | 8. DATE OF BIRTH <b>12-7-70</b>           |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>                         |                           | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>   | 9. AGE (In years last birthday) <b>79</b> |
| 13. FATHER'S NAME<br><b>Dean</b>   |                           | 11. BIRTHPLACE (State or foreign country)<br><b>Indiana</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)  |                           | 12. CITIZEN OF WHAT COUNTRY?<br><b>Indiana</b>   |   |
| 16. SOCIAL SECURITY NO.  |                           | 14. MOTHER'S MAIDEN NAME<br><b>Kate Whelan</b>   |   |
| 17. INFORMANT<br><b>Eugene J. Davis</b>  |                           | ADDRESS<br><b>Davis - 3015 Linwood Ave.</b>  |   |

|   |  |   |
|---|--|---|
| 18. <b>170x</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Carcinomatosis</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 months</b> |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Carcinoma of left breast</b>   |  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |   |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 19A. DATE OF OPERATION <b>Sept 19 48</b>  |  | 19B. MAJOR FINDINGS OF OPERATION<br><b>Carcinoma of left breast</b>                                       |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>6/22</b> 19 <b>50</b> , to <b>6/25</b> , 19 <b>50</b> that I last saw the deceased alive on <b>6/25</b> , 19 <b>50</b> . and that death occurred at <b>8:00</b> a.m., from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE<br><b>Paul G. Herold</b>   |  | 23B. ADDRESS<br><b>Maryland Gen. Hosp</b>   |  | 23C. DATE SIGNED<br><b>6-25-50</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Buried</b>  |  | 24B. DATE<br><b>6/28/50</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>                          |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>  |  | 25. FUNERAL DIRECTOR<br><b>H. W. Meeker</b>   |  |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 28 1950</b>  |  | REGISTRAR'S SIGNATURE<br><b>Wilmington Williams, Md.</b>  |  | ADDRESS<br><b>200 805 N. Calvert St.</b>  |  |





320  
50 5688HETTES  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

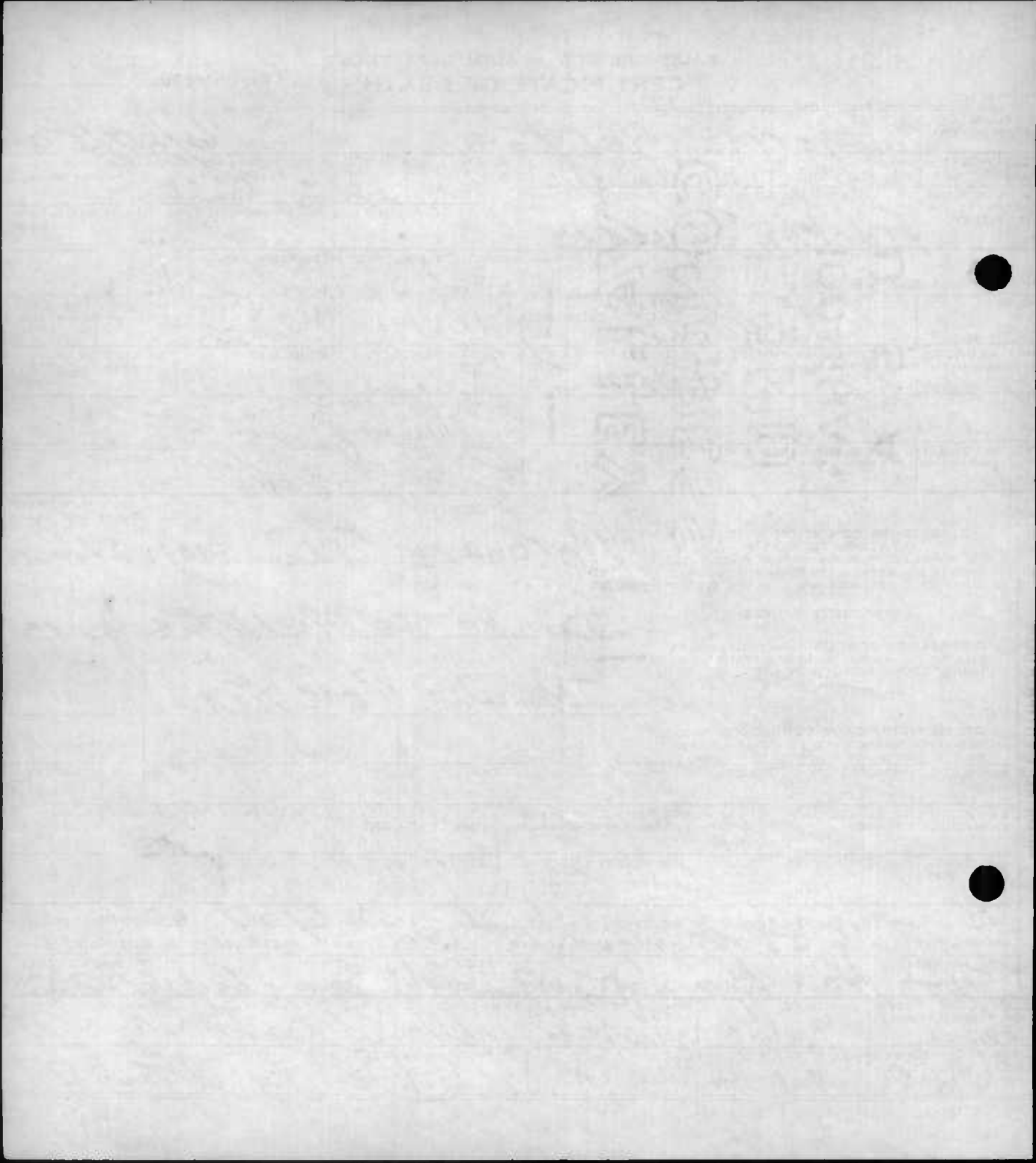
Registered No. 50 5688

BIRTH NO.

|   |                                  |   |  |  |  |
|---|----------------------------------|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Catherine Hettes</i>  |                                  |   | 2. DATE OF DEATH <i>6/27/50</i>  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>Franklin Square</i>  |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>Balt.</i> |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>36 Franklin Square</i>  |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>26-34</i>   |  |  |
| C. Length of stay in Baltimore<br>Yrs. Mos. Days  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><i>926 Spangler Way</i>   |  |  |
| 5. SEX<br><i>Female</i>   | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Married</i> | 8. DATE OF BIRTH<br><i>4/15/96</i>   | 9. AGE (In years last birthday)<br><i>55</i> | If Under 1 Year Months: Days If Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind and time done during most of working life, even if retired)<br><i>Housewife</i>      |                                  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>At Home</i>  |  |  |
| 11. BIRTHPLACE (State or foreign country)<br><i>Penna.</i>  |                                  |   | 12. CITIZEN OF WHAT COUNTRY?   |  |  |
| 13. FATHER'S NAME<br><i>John Jones</i>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><i>Catherine Davis</i>   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>No</i> |                                  |   | 16. SOCIAL SECURITY NO.<br><i>Linton W. Hettes</i>   |  |  |

|  |  |   |
|--|--|---|
| 18. <i>260X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | CAUSE OF DEATH<br>(A) <i>Coronary Occlusion</i><br>(B) <i>Diabetes Mellitus</i><br>(C) <i>Insulin Reaction</i> | INTERVAL BETWEEN ONSET AND DEATH<br><i>24 hours</i><br><i>years</i> |
|--|--|---|

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 19A. DATE OF OPERATION <i>0</i>   |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br><i>6/27/50</i>   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <i>6/26, 1950</i> to <i>6/27, 1950</i> , that I last saw the deceased alive on <i>6/27, 1950</i> , and that death occurred at <i>6:30 a.m.</i> , from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE<br><i>G. F. Hawkins Jr.</i>  |  | 23B. ADDRESS<br><i>Franklin Square, Balt.</i>   |  | 23C. DATE SIGNED<br><i>6/27/50</i>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Emmal</i>   |  | 24B. DATE<br><i>6/28/50</i>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Hornet Hill</i>                            |  |
| 24D. LOCATION (City, town, or county) (State)<br><i>Crown Pt. Ca</i>  |  | 25. FUNERAL DIRECTOR<br><i>W. J. Williams, M.D.</i>   |  | ADDRESS<br><i>1217 St Paul St</i>   |  |



300  
50 5689BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5689

BIRTH NO.

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Dorothy M WHITE</b>   |                                  | 2. DATE OF DEATH <b>June 24, 1950</b>  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY   |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Mercy Hospital</b>   |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)<br><b>Baltimore</b>  |  |
| c. Month of stay in Baltimore   |                                  | D. STREET ADDRESS (If rural, give location)<br><b>324 Kernway St.</b>  |  |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b>  | 8. DATE OF BIRTH<br><b>Feb, 1928</b>   |
| 9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Dictaphone operator</b>  |                                  | 9B. KIND OF BUSINESS OR INDUSTRY<br><b>Miss Kala Sine</b>  | 9. AGE (In years last birthday) <b>22</b><br>H Under 1 Year Months: Days<br>H Under 24 Hours Hours: Min. |
| 10. BIRTHPLACE (State or foreign country)<br><b>Mass</b>  |                                  | 11. CITIZEN OF WHAT COUNTRY?   |  |
| 12. FATHER'S NAME<br><b>Ernest White</b>  |                                  | 13. MOTHER'S MAIDEN NAME<br><b>Rose Loranger</b>   |  |
| 14. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)<br><b>No</b>   |                                  | 15. SOCIAL SECURITY NO.<br><b>213-28-5108</b>  |  |
| 16. CAUSE OF DEATH<br>18. <b>E981X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, athenia, etc. It means the disease, injury or complication which caused death.)<br><b>(A) Multiple gunshot wounds of chest</b><br>DUE TO<br>ANTECEDENT CAUSES<br><b>(B)</b><br>DUE TO<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>(C)</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                                  | 17. INFORMANT<br><b>Ethel West, 324 Kernway</b><br>ADDRESS   |  |
| 19A. DATE OF OPERATION  |                                  | 19B. MAJOR FINDINGS OF OPERATION   |  |
| 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                  |  |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.  |                                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>An apartment</b>  |  |
| 21C. WHERE DID INJURY OCCUR?<br><b>1213 N. Calvert St.</b>  |                                  | 21D. HOW DID INJURY OCCUR?<br><b>Firearms</b>  |  |
| 21E. TIME (Month) (Day) (Year) (Hour) OF INJURY<br><b>June 24, 1950 2:30 A.</b>   |                                  | 21F. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |
| 22. I certify that I took charge of the remains described above, held an <b>Autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> .   |                                  |  |  |
| 23A. SIGNATURE<br><b>R.S. Fisher</b>  |                                  | 23B. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/><br>M.D. |  |
| 23C. DATE SIGNED<br><b>June 24, 1950</b>  |                                  |  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>  |                                  | 24B. DATE<br><b>6/30/50</b>  |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>Northwood Memorial</b>   |                                  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md</b>  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 28 1950</b>  |                                  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b>  |  |
| 25. FUNERAL DIRECTOR<br><b>W. C. Jones</b>  |                                  | ADDRESS<br><b>1214 St. Paul</b>  |  |

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

NAME

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

TEMPERATURE

PULSE

BLOOD PRESSURE

WEIGHT

HEIGHT

HAIR

EYES

TEETH

SKIN

FEET

HANDS

NOSE

THROAT

STOMACH

INTESTINES

BLADDER

RECTUM

432  
50 5690

WILTSHIRE  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5690

BIRTH NO.

1. NAME OF DECEASED  
Type or Print *Eva Virginia Wiltshire*

2. DATE OF DEATH *6/27/50*

3. PLACE OF DEATH:  
A. Baltimore City, Maryland *Washington St*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE *Maryland* B. COUNTY *6-04*

5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)  
*420 N. Washington St.*

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
*Baltimore WASHINGTON ST*

7. STREET ADDRESS (If rural, give location)  
*420 N. Washington St.*

8. DATE OF BIRTH *1899* 9. AGE (In years last birthday) *71* 10. AGE (In years last birthday) *71* 11. BIRTHPLACE (State or foreign country) *Baltimore* 12. CITIZEN OF *USA*

13. Length of stay in Baltimore *71* Yrs. Mos. Days

14. FATHER'S NAME *John T. Stone* 15. MOTHER'S MAIDEN NAME *unknown*

16. SOCIAL SECURITY NO. *unknown*

17. INFORMANT *Mr. Albert Wiltshire* ADDRESS *420 N. Washington St.*

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
*Heart failure (from) Carcinoma, mouth (history) Atherosclerosis*

19. DATE OF OPERATION *0* 20. MAJOR FINDINGS OF OPERATION

21. ACCIDENT, SUICIDE, HOMICIDE (Specify) 22. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) 23. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

24. TIME (Month) (Day) (Year) (Hour) 25. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 26. HOW DID INJURY OCCUR?

27. I hereby certify that I attended the deceased from *6/25/50* to *6/27/50*, that I last saw the deceased alive on *6/25/50*, and that death occurred at *1431 N. Franklin St.*, from the causes and on the date stated above.

28. SIGNATURE *Maurice D. Shub* 29. ADDRESS *1431 N. Franklin St. Baltimore Md.* 30. DATE SIGNED *6/27/50*

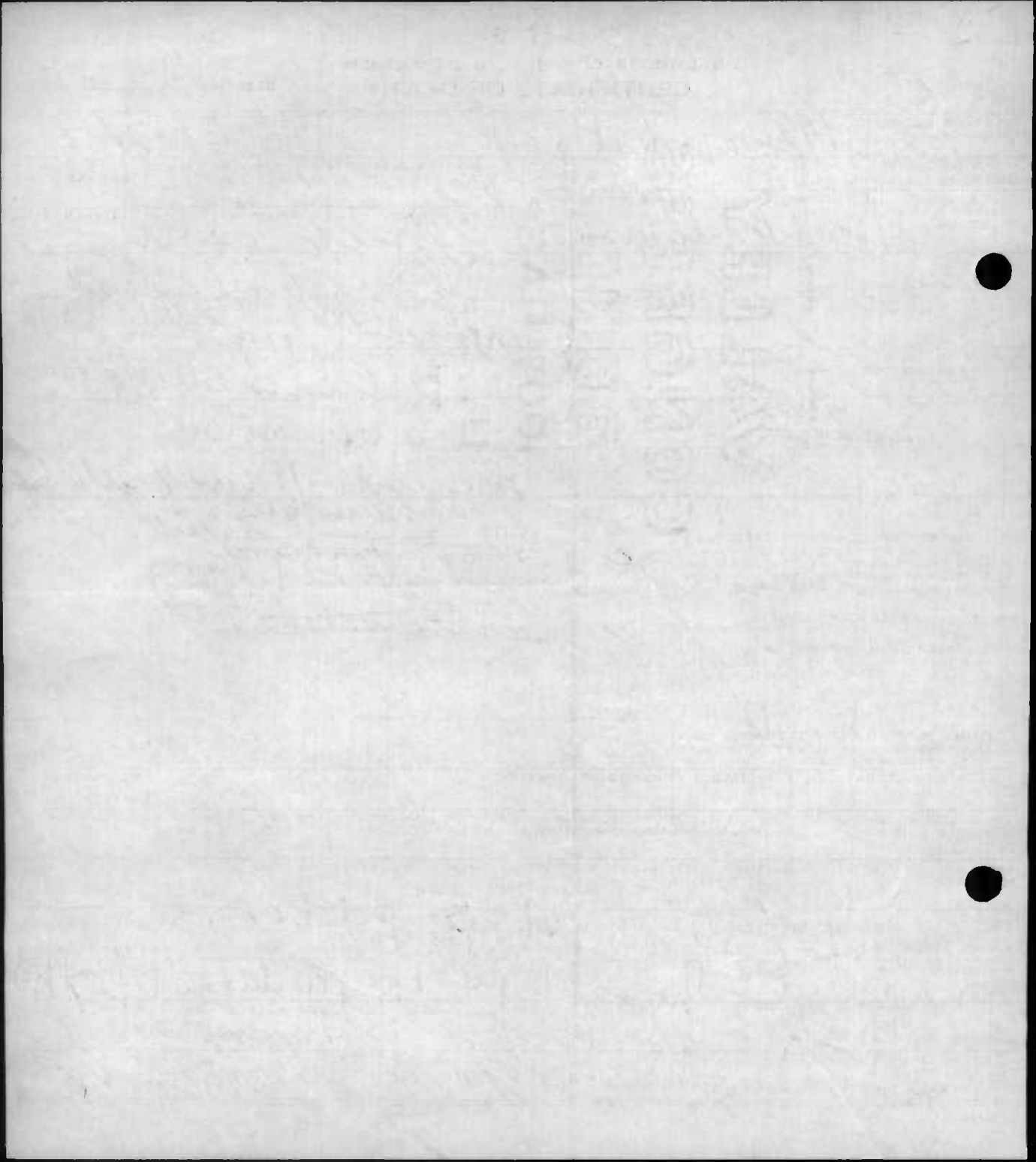
31. BURIAL, CREMATION, REMOVAL (Specify) *burial* 32. DATE *6/30/50* 33. NAME OF CEMETERY OR CREMATORY *London Park* 34. LOCATION (City, town, or county) (State) *Baltimore Md.*

35. RECEIVED BY *Wilmington William* 36. REGISTRAR'S SIGNATURE *Wilmington William* 37. FUNERAL DIRECTOR *Wilmington William* ADDRESS *1214 St Paul St*

JUN 28 1950 VS 150

1431 Kim Hill and 45c





530  
50 5691BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5691

|   |                           |  |   |  |   |
|---|---------------------------|--|---|--|---|
| BIRTH NO.   |                           | 1. NAME OF DECEASED<br>(Type or Print)   |   | 2. DATE OF DEATH   |   |
|   |                           | JOHN O. SMITH  |   | June 25, 1950  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland 901 S. Eaton St.  |                           |  |   | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE Md.<br>B. COUNTY |   |
| 5. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION   |                           |  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 26-09                    |   |
| 6. Length of stay in Baltimore<br>Yrs. Mos. Days  |                           |  |   | D. STREET ADDRESS (If rural, give location)<br>901 S. Eaton St.  |   |
| 7. SEX<br>Male  | 8. COLOR OR RACE<br>White | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Married   | 10. DATE OF BIRTH<br>May 31, 1886                           | 11. AGE (in years last birthday)<br>64   | 12. If Under 1 Year Months: Days<br>If Under 24 Hours Hours: Min. |
| 13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Machinist Helper  |                           |  | 14. BIRTHPLACE (State or foreign country)<br>Baltimore, Md. |  | 15. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                            |
| 16. FATHER'S NAME<br>George Dziennik  |                           |  | 17. MOTHER'S MAIDEN NAME<br>Sophia Buczkoiski               |  |   |
| 18. WAS DECEASED EVER IN U. S. ARMED FORCES? (es, no or unknown)<br>No  |                           |  | 19. SOCIAL SECURITY NO.<br>217-03-8425                      |  |   |
| 20. ADDRESS<br>Louise R. Smith 901 S. Eaton St.   |                           |  |   |  |   |
| 18. 40.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>ACUTE CORONARY THROMBOSIS<br>DUE TO<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                           |  |   | INTERVAL BETWEEN ONSET AND DEATH<br>5-31-50<br>6-25-50   |   |
| 19A. DATE OF OPERATION<br>June 20   |                           | 19B. MAJOR FINDINGS OF OPERATION   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                |   |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)<br>None  |                           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>None       |   | 21C. WHERE DID INJURY OCCUR?<br>None   |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY<br>None   |                           | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?<br>None   |   |
| 22. I hereby certify that I attended the deceased from 5-31, 1950 to 6-25, 1950, that I last saw the deceased alive on 6-25, 1950, and that death occurred at 11:00 P.M. from the causes and on the date stated above.  |                           |  |   |  |   |
| 23A. SIGNATURE<br>J. Schlemmer  |                           | 23B. ADDRESS<br>M. D. 842 E. E. St.  |   | 23C. DATE SIGNED<br>6-27-50  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                           | 24B. DATE<br>June 28 1950  |   | 24C. NAME OF CEMETERY OR CREMATORY<br>Moreland Memorial Cem.   |   |
|   |                           |  |   | 24D. LOCATION (City, town, or county) (State)<br>Taylor Ave. Balto. Co., Md.                                       |   |
| 25. DATE RECEIVED BY LOCAL REGISTRAR<br>JUN 28 1950   |                           | 26. REGISTRAR'S SIGNATURE<br>Huntington Williams, M.D.   |   | 27. FUNERAL DIRECTOR<br>Charles S. Geiler  |   |
|   |                           |  |   | 28. ADDRESS<br>901 S. Conkling St.   |   |

44637

94a

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

OFFICE OF THE CHIEF, BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

TO THE DIRECTOR, BUREAU OF PLANT INDUSTRY  
FROM THE CHIEF, BUREAU OF PLANT INDUSTRY

SUBJECT: [Illegible]

DATE: [Illegible]

RE: [Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

254  
50 5692BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5692

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Thomas M. F. McNally

2. DATE  
OF DEATH June 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

University Hospital

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

SEPARATED

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

UNKNOWN HOTEL CLERK

13. FATHER'S NAME

THOMAS McNALLY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)

Yes, no or unknown

YES

W. W. #1

16. SOCIAL SECURITY NO.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL, and give township)

Baltimore

22-02

D. STREET ADDRESS (If rural, give location)

326 W. Camden St.

8. DATE OF BIRTH

FEB. 14, 1888

9. AGE (In years last birthday)

62

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

11. BIRTHPLACE (State or foreign country)

NEW YORK, N.Y.

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

MARGARET McNALLY

17. INFORMANT

ADDRESS

MARY PHILLIPS 456 6TH AVE BROOKLYN NY

18.

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Myocardial infarct

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Cirrhosis of liver

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an AUTOPSY (exam) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED June 26, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUN 28 1950

Huntington Williams, Jr.

Wm Cook, Inc. 1217 St. Paul St.

7 S 151

26687

124B V

BRISTOL CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

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DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

| BALTIMORE CITY HEALTH DEPARTMENT   |                                  |   |   | Registered No.  |  |  |  |
|--|----------------------------------|---|---|---|--|--|--|
| CERTIFICATE OF DEATH   |                                  |   |   |   |  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Scott L awson</b>  |                                  |   |   | 2. DATE OF DEATH <b>June 24 1950</b>  |  |  |  |
| 3. PLACE OF DEATH:<br><b>Baltimore City, Maryland</b>  |                                  |   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY |  |  |  |
| 5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br><b>Baltimore City Hospitals</b><br>N. HOSPITAL OR INSTITUTION <b>4940 Eastern Avenue</b>  |                                  |   |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>22-01</b>               |  |  |  |
| 6. Length of stay in Baltimore <b>30 Yrs.</b> Yrs. Mos. Days   |                                  |   |   | D. STREET ADDRESS (If rural, give location)<br><b>117 W. Montgomery St.</b>   |  |  |  |
| 7. SEX<br><b>Male</b>  | 8. COLOR OR RACE<br><b>Negro</b> | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Single</b>                                      | 10. DATE OF BIRTH<br><b>Feb 15 1884</b>         |   | 11. AGE (in years last birthday) <b>66</b> |  |  |
| 12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>PLUMBER</b>   |                                  |   | 13. KIND OF BUSINESS OR INDUSTRY<br><b>CONV</b> |   |  | 14. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>                         |  |
| 15. FATHER'S NAME<br><b>(D)</b>  |                                  |   | 16. MOTHER'S MAIDEN NAME<br><b>(D)</b>          |   |  | 17. CITIZEN OF WHAT COUNTRY?   |  |
| 18. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)   |                                  |   | 19. SOCIAL SECURITY NO.                         |   |  | 20. INFORMANT <b>Baltimore City Hospitals</b><br><b>Records* 4940 Eastern Avenue</b> |  |
| 21. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cerebral Thrombosis</b><br>DUE TO<br>INTERVAL BETWEEN ONSET AND DEATH |                                  |   |   |   |  |  |  |
| 22. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Arteriosclerotic Heart Disease</b><br>DUE TO<br>(B)<br>DUE TO<br>(C)  |                                  |   |   |   |  |  |  |
| 23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                                  |   |   |   |  |  |  |
| 24. DATE OF OPERATION <b>2</b>   |                                  | 25. MAJOR FINDINGS OF OPERATION   |   |   |  | 26. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 27. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |                                  | 28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |   | 29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  |  |
| 30. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                  | 31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |   | 32. HOW DID INJURY OCCUR?   |  |  |  |
| 33. I hereby certify that I attended the deceased from <b>June 15</b> , 19 <b>50</b> to <b>June 24</b> , 19 <b>50</b> that I last saw the deceased alive on <b>June 24</b> , 19 <b>50</b> , and that death occurred at <b>10:20 AM</b> from the causes and on the date stated above.             |                                  |   |   |   |  |  |  |
| 34. SIGNATURE <b>R. J. Popen</b>   |                                  | 35. ADDRESS <b>Baltimore City Hospitals</b><br><b>4940 Eastern Avenue</b>                             |   | 36. DATE SIGNED <b>6-26-50</b>  |  |  |  |
| 37. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 38. DATE<br><b>6/28/1950</b>  |   | 39. NAME OF CEMETERY OR CREMATORY<br><b>Mt Auburn Ct</b>  |  | 40. LOCATION (City, town, or county) (State)<br><b>Balt City</b>                     |  |
| 41. DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 28 1950</b>   |                                  | 42. REGISTRAR'S SIGNATURE<br><b>Wilmington Williams, M.D.</b>   |   | 43. FUNERAL DIRECTOR<br><b>108 W</b>  |  | 44. ADDRESS<br><b>G. L. Brown &amp; Son - Montgomery St</b>                          |  |
| VS 150   |                                  |   |   |   |  |  |  |

348 V9

931





240

50 5694

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5694  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Willie Boswell

2. DATE  
OF  
DEATH

23 June 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

38 University

C. Length of stay in Baltimore

5. SEX

M.

6. COLOR OR RACE

Col.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Separated

Yrs.  
Mos.  
Days

50 yrs

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR  
INDUSTRY

H.D. Supply &amp; Co.

13. FATHER'S NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes, no or unknown

16. SOCIAL  
SECURITY NO.4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

17-03

D. STREET ADDRESS (If rural, give location)

522 N. Pine St

8. DATE OF BIRTH

1885

9. AGE (In years  
last birthday)

65

II Under 1 Year  
Months: DaysII Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Norfolk, Va.

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Unknown

17. INFORMANT

Charles Brown, 522 N. Pine St

ADDRESS

18. 443 X

CAUSE OF DEATH

Cerebro-vascular accident

INTERVAL BETWEEN  
ONSET AND DEATH

3 days

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Hypertensive Cardio-vascular  
disease

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Congestive heart failure

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
C. H. JURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 21 June 1950, to 23 June 1950, that I last saw the  
deceased alive on 23 June 1950, and that death occurred at 2:15 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Gerald C. Martin

M. D.

23B. ADDRESS

University Hoop

23C. DATE SIGNED

16 June 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

6-28-50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county) (State)

Baltimore 30.

DATE RECEIVED BY  
LOCAL REGISTRAR

JUN 28 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Wm. A. Jackson - 916 Penna. Ave.

ADDRESS

CENTRICITY OF DEATH

134

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5695  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*ISAAC WASSERMAN*

2. DATE  
OF  
DEATH

*6-27-50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

*2400 Allendale Road*

C. Length of stay in Baltimore

*19*

Yrs.  
Mons  
Days

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

*2400 Allendale Road*

5. SEX

*Male*

6. COLOR OR RACE

*White*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*Married*

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year Months Days If Under 24 Hours Hours Min.

*80*

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Retired*

10B. KIND OF BUSINESS OR INDUSTRY

*Pawn broker*

11. BIRTH PLACE (State or foreign country)

*Russia*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*Mordecai*

14. MOTHER'S MAIDEN NAME

*Miriam*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*Sora Wasserman*

*Same*

18. *331X*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

*Cerebral hemorrhage, and paralysis*

*5 days*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

*Advanced arteriosclerosis*

*?*

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *June 22/50* 19*50*, to *6/27/50* 19*50*, that I last saw the deceased alive on *June 27*, 19*50*, and that death occurred at *5:20* p. m., from the causes and on the date stated above.

23A. SIGNATURE

*Charles S. Rublett*

23B. ADDRESS

*2220 Harrison Blvd*

23C. DATE SIGNED

*June 28/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

*Burial*

*6-28-50*

*Beth T. Teloh*

*Balto*

*Md*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*JUN 28 1950*

*Christington Williams, M.D.*

*Jack Henry, Jr.*

*2100 Canton Rd*

Hublett  
2220 Garrison Blvd  
he 7600  
8-10

---

**WINTERBERG**  
BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

Registered No. **50 5696**

BIRTH NO.

|  |                               |  |                  |
|--|-------------------------------|--|------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>HILDA WINTERBERG</b>   |                               | 2. DATE OF DEATH <b>6.27.50.</b>   |                  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>Baltimore</b>   |                               | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> COUNTY |                  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR <b>Lincoln Hospital</b><br>INSTITUTION <b>42</b> |                               | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 15 27-18</b>                |                  |
| D. STREET ADDRESS (If rural, give location)<br><b>3831 W. Gamin Ave</b>  |                               |  |                  |
| c. Length of stay in Baltimore <b>9</b> Yrs. Mos. Days   |                               |  |                  |
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>   | 8. DATE OF BIRTH |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House wife</b>                                     |                               | 10b. KIND OF BUSINESS OR INDUSTRY  |                  |
| 13. FATHER'S NAME<br><b>Meyer</b>  |                               | 11. BIRTHPLACE (State or foreign country)<br><b>Germany</b>  |                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)   |                               | 16. SOCIAL SECURITY NO.  |                  |
| 17. INFORMANT<br><b>Solomon Winterberg</b>   |                               | ADDRESS<br><b>Saul</b>   |                  |
| 12. CITIZEN OF WHAT COUNTRY?   |                               | 14. MOTHER'S MAIDEN NAME<br><b>Bertha</b>  |                  |

|   |   |  |
|---|---|--|
| 18. <b>198.1</b> CAUSE OF DEATH   |   | INTERVAL BETWEEN ONSET AND DEATH   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>(A) Probable Lymphoma.</b> |   | <b>1 mo</b>  |
| DUE TO  |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>(B)</b>  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>(C)</b>   |   |  |
| 19A. DATE OF OPERATION<br><b>6.8.50.</b>  | 19b. MAJOR FINDINGS OF OPERATION<br><b>Biopsy of Neck Mass - Report? Possible Lymphoma</b>                |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |

22. I hereby certify that I attended the deceased from **6.3.**, 19**50**, to **6.27**, 19**50**, that I last saw the deceased alive on **6.27**, 19**50**, and that death occurred at **11:30 p.m.**, from the causes and on the date stated above.

|  |                             |   |  |   |  |
|--|-----------------------------|---|--|---|--|
| 23A. SIGNATURE<br><b>M. Becker</b>                         |                             | 23b. ADDRESS<br><b>Lincoln Hospital</b>               |  | 23c. DATE SIGNED<br><b>6.28.50.</b>       |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24B. DATE<br><b>6-28-50</b> | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Rosedale</b> | 24D. LOCATION (City, town, or county) (State)<br><b>Balto Md</b> |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 28 1950</b>     |                             | REGISTRAR'S SIGNATURE<br><b>William H. Williams</b>   |  | 25. FUNERAL DIRECTOR<br><b>Jack Lewis</b> |  |
|  |                             |   |  | ADDRESS<br><b>2100 Eutaw Pl</b>           |  |



OFFICE OF THE ATTORNEY GENERAL  
STATE OF NEW YORK

IN SENATE, JANUARY 12, 1933.

REPORT OF THE ATTORNEY GENERAL, JAMES C. MCGILL, ON THE

ADMINISTRATION OF THE OFFICE DURING THE YEAR 1932.

ALBANY: JAMES C. MCGILL, ATTORNEY GENERAL, 1933.

PRINTED BY THE STATE PRINTING OFFICE, ALBANY, N. Y.

RECEIVED JAN 15 1933

STATE OF NEW YORK

OFFICE OF THE ATTORNEY GENERAL

ALBANY, N. Y.

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OFFICE OF THE ATTORNEY GENERAL

ALBANY, N. Y.

| 534<br>50 5697   |                             | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH   |                            | Registered No. 50 5697  |   |
|--|-----------------------------|--|----------------------------|---|---|
| BIRTH NO. 50-09461   |                             | 1. NAME OF DECEASED<br>(Type or Print) LAWRENCE RANDALL  |                            | 2. DATE OF DEATH June 24, 1950  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland |                            | B. COUNTY   |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>University Hospital   |                             | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 16-02            |                            |   |   |
| C. Length of stay in Baltimore 6 wks.  |                             | D. STREET ADDRESS (If rural, give location)<br>904 N. Carey Street   |                            |   |   |
| 5. SEX<br>Male   | 6. COLOR OR RACE<br>Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Single  | 8. DATE OF BIRTH<br>5-?-50 | 9. AGE (In years last birthday)<br>6 wks  | 10. USUAL OCCUPATION (If kind of work done during most of working life even if retired)<br>Infant |
| 10A. USUAL OCCUPATION (If kind of work done during most of working life even if retired)<br>Infant   |                             | 10B. KIND OF BUSINESS OR INDUSTRY<br>none  |                            | 11. BIRTHPLACE (State or foreign country)<br>Md.                                    |   |
| 12. CITIZEN OF WHAT COUNTRY?<br>W.D.A.   |                             | 13. FATHER'S NAME<br>Randall   |                            | 14. MOTHER'S MAIDEN NAME<br>?   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)<br>no   |                             | 16. SOCIAL SECURITY NO.<br>none  |                            | 17. INFORMANT<br>Mrs Randall - Carey St.  |   |
| 18. 391.0  |                             | CAUSE OF DEATH   |                            | INTERVAL BETWEEN ONSET AND DEATH  |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   |                             | (A) OTITIS MEDIA - ACUTE<br>Bilateral  |                            | 3 hrs   |   |
| ANTECEDENT CAUSES  |                             | (B)  |                            |   |   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |                             | (C)  |                            |   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                             |  |                            |   |   |
| 19A. DATE OF OPERATION   |                             | 19B. MAJOR FINDINGS OF OPERATION   |                            | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                   |                            | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                             | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>     |                            | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |                             |  |                            |   |   |
| 23A. SIGNATURE<br>J. Fisher  |                             | 23B. CHIEF MEDICAL EXAMINER.....<br>M.D. ASSISTANT MEDICAL EXAMINER.....<br>MEDICAL INVESTIGATOR.....      |                            | 23C. DATE SIGNED<br>6-25-50   |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |                             | 24B. DATE<br>6/28/50   |                            | 24C. NAME OF CEMETERY OR CREMATORY<br>Mt Auburn                                     |   |
| 24D. LOCATION (City, town, or county)<br>89a   |                             | 24E. LOCATION (City, town, or county)<br>89a   |                            | 24F. LOCATION (City, town, or county)<br>89a  |   |
| DATE RECEIVED BY LOCAL REGISTRAR<br>JUN 28 1950  |                             | REGISTRAR'S SIGNATURE<br>Huntington Williams, M.D.   |                            | 25. FUNERAL DIRECTOR<br>A. Holstead - 918 -<br>Rivers Hill Ave                      |   |



516

50 5698

# TAMPER

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 5698  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Lillie Tamper

2. DATE  
OF  
DEATH

6/24/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

1516 Rutter St.

C. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Baltimore 14-01

D. STREET ADDRESS (If rural, give location)

1516 Rutter St.

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

?? 1875

9. AGE (In years last birthday)

75

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Jacob Milmer

14. MOTHER'S MAIDEN NAME

Lillie ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Lillian Williams - 1516 Rutter St.

ADDRESS

18. 331X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Cerebral Hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

arterio. sclerosis

15 min

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 1, 1949, to June 17, 1950, that I last saw the deceased alive on June 19, 1950 and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

Lillian Williams

23B. ADDRESS

2329 Greenfield L

23C. DATE SIGNED

June 27, 50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

6/28/50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Lillian Williams

25. FUNERAL DIRECTOR

W. Halstead - 918 South Hill Ave

ADDRESS

CHICAGO, ILL., MAY 1, 1934

TO THE EDITOR: I have the honor to acknowledge the receipt of your letter of April 27, 1934, regarding the matter of the

publication of the article on the subject of the

importance of the study of the

history of the

development of the

science of the

art of the

profession of the

practice of the

management of the

operation of the

administration of the

organization of the

structure of the

system of the

method of the

process of the

procedure of the

protocol of the

regulation of the

control of the

supervision of the

536

50 5699

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5699  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN SANDERS

2. DATE  
OF  
DEATH

6-25-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION146 Dolphin St  
18

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR  
INDUSTRY

Construction

13. FATHER'S NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

no

none

16. SOCIAL  
SECURITY NO.

none

8. DATE OF BIRTH

??/1864

9. AGE (In years,  
last birthday)

86

11 Under 1 Year  
Months Days11 Under 24 Hours  
Hours Min.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY

U. S. A.

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

no

none

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT

Mrs Sanders - 146 - Dolphin St.

18.

332X I

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) cerebral thrombosis

DUE TO

48 hrs.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) generalized arteriosclerosis

DUE TO

3 years

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 1950 to June 25, 1950 that I last saw the  
deceased alive on June 25, 1950, and that death occurred at 11:05 a. m., from the causes and on the date stated above.

23A. SIGNATURE

James D. Carr M. D.

23B. ADDRESS

1427 Madison Ave.

23C. DATE SIGNED

6-26-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

6/29/50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary

24D. LOCATION (City, town or county)

Cedar Hill Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Wm. Halstead - 918 -

Quind Hill ave. 83B



Page 1

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# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 50 5700

|   |                                 |   |                                 |   |                               |
|---|---------------------------------|---|---------------------------------|---|-------------------------------|
| BIRTH NO.   |                                 | 1. NAME OF DECEASED<br>(Type or Print) <u>MARTHA STERLING</u>   |                                 | 2. DATE OF DEATH <u>June 19, 1950</u>   |                               |
| 3. PLACE OF DEATH:<br>A. <u>Baltimore City, Maryland</u>  |                                 | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>Maryland</u><br>B. COUNTY <u>Baltimore</u>                   |                                 |   |                               |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u>  |                                 | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u> <u>4-02</u>   |                                 |   |                               |
| C. Length of stay in Baltimore <u>30</u> Yrs. Mos. Days   |                                 | D. STREET ADDRESS (If rural, give location) <u>705 Vine Street</u>  |                                 |   |                               |
| 5. SEX <u>female</u>  | 6. COLOR OR RACE <u>colored</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>   | 8. DATE OF BIRTH <u>??/1893</u> | 9. AGE (In years last birthday) <u>57</u>   | 10. Under 1 Year Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundress</u>  |                                 | 10B. KIND OF BUSINESS OR INDUSTRY <u>Public Room</u>  |                                 | 11. BIRTHPLACE (State or foreign country) <u>Winnabow, S.C.</u>                     |                               |
| 13. FATHER'S NAME <u>unknown</u>  |                                 | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |                                 |   |                               |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no) <u>no</u>   |                                 | 16. SOCIAL SECURITY NO. <u>215-18-5975</u>  |                                 | 17. INFORMANT <u>Walter Sawyer - 710 St.</u>  |                               |
| 18. <u>420.1</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><u>Coronary artery sclerosis</u><br>DUE TO  |                                 | INTERVAL BETWEEN ONSET AND DEATH  |                                 |   |                               |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO  |                                 |   |                                 |   |                               |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                                 |   |                                 |   |                               |
| 19A. DATE OF OPERATION  |                                 | 19B. MAJOR FINDINGS OF OPERATION  |                                 | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                               |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                 | 21B. PLACE OF INJURY (e.g., to or about home, farm, factory, street, office bldg., etc.)  |                                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |                               |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                 | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>m. WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>    |                                 | 21F. HOW DID INJURY OCCUR?  |                               |
| 22. I certify that I took charge of the remains described above, held an <u>autopsy</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |                                 |   |                                 |   |                               |
| 23A. SIGNATURE <u>Stanley H. Dunne</u> M.D.   |                                 | 23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/> |                                 | 23C. DATE SIGNED <u>June 19, 1950</u>   |                               |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                                 | 24B. DATE <u>6-1-50</u>   |                                 | 24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>                               |                               |
| 24D. LOCATION (City, town, or county) (State) <u>Cedar Hill Md</u>  |                                 | 24E. REGISTRAR'S SIGNATURE <u>Wm. Williams, M.D.</u>  |                                 | 25. FUNERAL DIRECTOR <u>A. Halstead - 918 -</u>                                     |                               |
| DATE RECEIVED BY LOCAL REGISTRAR  |                                 | ADDRESS   |                                 | 44888 <u>Alvin Hill and</u> 94a   |                               |

MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

IN THE CITY OF

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Nurse

Signature of Family Member

Signature of Burial Officer

Signature of Undertaker

Signature of Cemetery Officer

Signature of Funeral Home

Signature of Mortuary

Signature of Embalmer

Signature of Crematorium

Signature of Interment

Signature of Burial

Signature of Final Disposition

320  
50

5701

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5701

|  |                                    |  |   |  |   |
|--|------------------------------------|--|---|--|---|
| BIRTH NO.  |                                    |  | 2. DATE OF DEATH 6-27-50  |  |   |
| 1. NAME OF DECEASED (Type or Print) <i>Curtis Fitts</i>  |                                    |  | 528193  |  |   |
| 3. PLACE OF DEATH:<br>a. Baltimore City, Maryland  |                                    |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Md.</i><br>B. COUNTY |  |   |
| b. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>JOHNS HOPKINS HOSPITAL</i>                                     |                                    |  | c. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)<br><i>Baltimore</i>                         |  |   |
| c. Length of stay in Baltimore <i>10</i>   |                                    |  | d. STREET ADDRESS (If rural, give location)<br><i>1609 Bruce Ct</i>   |  |   |
| 5. SEX<br><i>male</i>  | 6. COLOR OR RACE<br><i>colored</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>M.</i> | 8. DATE OF BIRTH<br><i>5-15-09</i>  | 9. AGE (in years last birthday)<br><i>41</i> | If Under 1 Year Months: Days<br>If Under 24 Hours Hours: Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Barber</i> |                                    |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Barber Shop</i>   |  |   |
| 13. FATHER'S NAME<br><i>Fitts</i>  |                                    |  | 11. BIRTHPLACE (State or foreign country)<br><i>N.C.</i>  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><i>no</i>             |                                    |  | 16. SOCIAL SECURITY NO.<br><i>none</i>  |  |   |
| 14. MOTHER'S MAIDEN NAME<br><i>unknown.</i>  |                                    |  | 17. INFORMANT ADDRESS<br><i>JOHNS HOPKINS HOSPITAL</i>  |  |   |

|  |   |  |
|--|---|--|
| 18. <i>201X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Hodgkins Disease</i> | CAUSE OF DEATH<br>(A) .....<br>DUE TO<br>(B) .....<br>(C) ..... | INTERVAL BETWEEN ONSET AND DEATH<br><i>4 mos</i> |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |   |  |

|  |  |  |  |   |
|--|--|--|--|---|
| 19a. DATE OF OPERATION   |  | 19b. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                     | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |   |
| 21d. TIME (Month) (Day) (Year) (Hour)  | 21e. INJURY OCCURRED<br>WHILE AT <input type="checkbox"/> WORK<br>NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR?   |  |   |
| 22. I hereby certify that I attended the deceased from <i>5-26-</i> , 1950, to <i>6-27-</i> , 1950, that I last saw the deceased alive on <i>6-27-</i> , 1950, and that death occurred at <i>6:16 AM</i> , from the causes and on the date stated above. |  |  |  |   |
| 23a. SIGNATURE<br><i>David E. Rogers</i>   |  | 23b. ADDRESS<br><i>JOHNS HOPKINS HOSPITAL</i>                            |  | 23c. DATE SIGNED<br><i>6/27/50</i>  |

|   |   |   |  |
|---|---|---|--|
| 24a. BURIAL, CREMATION, DEMONSTRATION Specify<br><i>Shipped</i> | 24b. DATE<br><i>6/30/50</i>                               | 24c. NAME OF CEMETERY OR CREMATORY<br><i>Norlina N.C.</i> | 24d. LOCATION (City, town, or county) (State)<br><i>W. H. Halstead - 918 -<br/>Blund Hill Ave.</i> |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUN 28 1950</i>          | REGISTRAR'S SIGNATURE<br><i>Huntington Williams, M.D.</i> | 25. FUNERAL DIRECTOR ADDRESS<br><i>70089</i>              |  |

Hodgkins Disease 4 mos

James E. Rogers

520  
50 5702

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5702  
Registered No.

BIRTH NO.

|  |                                 |  |                                       |
|--|---------------------------------|--|---------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>VICTORIA JONES</b>   |                                 | 2. DATE OF DEATH <b>24 June 50</b>   |                                       |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                 | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>md.</b> B. COUNTY <b>city</b> |                                       |
| 5. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>good Samaritan Hosp</b><br>60 27 <b>N. Carey St</b> |                                 | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>12-05</b>                      |                                       |
| 6. LENGTH OF stay in Baltimore <b>11 mo</b>  |                                 | D. STREET ADDRESS (If rural, give location)<br><b>438- Pittman Pl.</b>   |                                       |
| 7. SEX <b>Female</b>   | 8. COLOR OR RACE <b>Colored</b> | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>   | 10. DATE OF BIRTH <b>Dec. 15 1884</b> |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laundress.</b>                                |                                 | 12. KIND OF BUSINESS OR INDUSTRY<br><b>Union Mem. Hosp.</b>  |                                       |
| 13. FATHER'S NAME<br><b>John Boston</b>  |                                 | 14. MOTHER'S MAIDEN NAME<br><b>Mary Jane ?</b>   |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>  |                                 | 16. SOCIAL SECURITY NO. <b>none</b>  |                                       |
| 17. INFORMANT <b>Elizabeth Brown - 438 Pittman Place</b>   |                                 | 18. ADDRESS <b>438 Pittman Place</b>   |                                       |

18. **443X** CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(A) **Cerebral thrombosis**

(B) **hypertensive and arteriosclerotic cardiovascular disease**

(C)

19A. DATE OF OPERATION **0** 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

|  |  |  |
|--|--|--|
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |

22. I hereby certify that I attended the deceased from **14 June, 1950**, to **24 June, 1950**, that I last saw the deceased alive on **23 June, 1950**, and that death occurred at **4:20 Pm.**, from the causes and on the date stated above.

|   |                                    |  |
|---|------------------------------------|--|
| 23A. SIGNATURE <b>Emil H. Henning Jr.</b> M. D.         | 23B. ADDRESS <b>601 Winans Way</b> | 23C. DATE SIGNED <b>26 June 50</b>                   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> | 24B. DATE <b>6/28/50</b>           | 24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b> |
| 24D. LOCATION (City, town, or county) <b>Baltimore</b>  |                                    | 24E. LOCATION (State) <b>md.</b>                     |

25. FUNERAL DIRECTOR **Chas. H. Alexander** ADDRESS **1204 44th St**



CERTIFICATE OF DEATH

|                             |  |                                  |  |                            |  |                                  |  |                                  |  |
|-----------------------------|--|----------------------------------|--|----------------------------|--|----------------------------------|--|----------------------------------|--|
| 1. Name of Deceased         |  | 2. Sex                           |  | 3. Age                     |  | 4. Date of Birth                 |  | 5. Date of Death                 |  |
| 6. Place of Birth           |  | 7. Occupation                    |  | 8. Cause of Death          |  | 9. Place of Death                |  | 10. Signature of Registrar       |  |
| 11. Name of Informant       |  | 12. Relationship to Deceased     |  | 13. Signature of Informant |  | 14. Date of Report               |  | 15. Signature of Medical Officer |  |
| 16. Name of Medical Officer |  | 17. Signature of Medical Officer |  | 18. Date of Report         |  | 19. Signature of Registrar       |  | 20. Date of Report               |  |
| 21. Name of Registrar       |  | 22. Signature of Registrar       |  | 23. Date of Report         |  | 24. Signature of Medical Officer |  | 25. Date of Report               |  |
| 26. Name of Medical Officer |  | 27. Signature of Medical Officer |  | 28. Date of Report         |  | 29. Signature of Registrar       |  | 30. Date of Report               |  |
| 31. Name of Registrar       |  | 32. Signature of Registrar       |  | 33. Date of Report         |  | 34. Signature of Medical Officer |  | 35. Date of Report               |  |
| 36. Name of Medical Officer |  | 37. Signature of Medical Officer |  | 38. Date of Report         |  | 39. Signature of Registrar       |  | 40. Date of Report               |  |
| 41. Name of Registrar       |  | 42. Signature of Registrar       |  | 43. Date of Report         |  | 44. Signature of Medical Officer |  | 45. Date of Report               |  |
| 46. Name of Medical Officer |  | 47. Signature of Medical Officer |  | 48. Date of Report         |  | 49. Signature of Registrar       |  | 50. Date of Report               |  |
| 51. Name of Registrar       |  | 52. Signature of Registrar       |  | 53. Date of Report         |  | 54. Signature of Medical Officer |  | 55. Date of Report               |  |
| 56. Name of Medical Officer |  | 57. Signature of Medical Officer |  | 58. Date of Report         |  | 59. Signature of Registrar       |  | 60. Date of Report               |  |
| 61. Name of Registrar       |  | 62. Signature of Registrar       |  | 63. Date of Report         |  | 64. Signature of Medical Officer |  | 65. Date of Report               |  |
| 66. Name of Medical Officer |  | 67. Signature of Medical Officer |  | 68. Date of Report         |  | 69. Signature of Registrar       |  | 70. Date of Report               |  |
| 71. Name of Registrar       |  | 72. Signature of Registrar       |  | 73. Date of Report         |  | 74. Signature of Medical Officer |  | 75. Date of Report               |  |
| 76. Name of Medical Officer |  | 77. Signature of Medical Officer |  | 78. Date of Report         |  | 79. Signature of Registrar       |  | 80. Date of Report               |  |
| 81. Name of Registrar       |  | 82. Signature of Registrar       |  | 83. Date of Report         |  | 84. Signature of Medical Officer |  | 85. Date of Report               |  |
| 86. Name of Medical Officer |  | 87. Signature of Medical Officer |  | 88. Date of Report         |  | 89. Signature of Registrar       |  | 90. Date of Report               |  |
| 91. Name of Registrar       |  | 92. Signature of Registrar       |  | 93. Date of Report         |  | 94. Signature of Medical Officer |  | 95. Date of Report               |  |
| 96. Name of Medical Officer |  | 97. Signature of Medical Officer |  | 98. Date of Report         |  | 99. Signature of Registrar       |  | 100. Date of Report              |  |

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 5703**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*Olivia Collins*

2. DATE  
OF  
DEATH

*June 26, 1950*

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE *md* B. COUNTY *C*

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

*516 N. Bond St.*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
*Baltimore 7-05*

C. Length of stay in Baltimore *20 yrs.* Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location)  
*516 N. Bond St.*

5. SEX *F*

6. COLOR OR RACE *Colored*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
*married*

8. DATE OF BIRTH *Jan 21, 1905*

9. AGE (In years last birthday) *45* If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
*Housewife*

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)  
*Brooklyn Pa.*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME  
*Unknown*

14. MOTHER'S MAIDEN NAME  
*Mollie Smith*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or no known) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
*Olivia Collins*

18. *332X*

**CAUSE OF DEATH**

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Cerebral Thrombosis*

*2 months*

DUE TO

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

**II**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT.

(C)

19A. DATE OF OPERATION *0*

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *June 12, 1950*, to *June 26, 1950*, that I last saw the deceased alive on *June 22, 1950*, and that death occurred at *1:45 A. m.*, from the causes and on the date stated above.

23A. SIGNATURE  
*Robert W. M. Daniel*

23B. ADDRESS  
*807 N. Caroline St*

23C. DATE SIGNED  
*June 27, 1950*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*June 28, 1950*

*Wilmington Williams, M.*

*Miss Robert G. Elliott, Daughter*

*832 129 N. Caroline St*

MEDICAL CERTIFICATION



E-355

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5704

BIRTH NO. 50 5704

1. NAME OF DECEASED  
(Type or Print)

ROBERTA EDMONDS

2. DATE  
OF  
DEATH

6/27/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

646 W Conway St

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

MD

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 22-02

D. STREET ADDRESS (If rural, give location)

646 W Conway St

C. Length of stay in Baltimore

15

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

Caucasian

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

1891

9. AGE (In years  
last birthday)

59

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Home -

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Phil Hines

14. MOTHER'S MAIDEN NAME

Lucille Brooks

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Anna MacRobison 646 Conway

18. 331X I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Cerebral Hemorrhage

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Hypertension -  
arteriosclerosis

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/25/50 to 6/27/50, that I last saw the  
deceased alive on 6/27/50, and that death occurred at 10:20 a. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUN 28 1950

William Williams

Isaiah R Brown Son 108 W Montgomery

DEPARTMENT OF HEALTH  
STATE OF NEW YORK

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE

SEX

RACE

V-230

50 5705

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHX 50 5705  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ROBERT L. VEST

2. DATE  
OF  
DEATH

28 June 50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Church Home &amp; Hospital

C. Length of stay in Baltimore

7

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

S

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

Maryland Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 19 JONES CREEK

D. STREET ADDRESS (If rural, give location)

2200 Lincoln Ave 5300

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

- NONE

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Roy L. Vest

14. MOTHER'S MAIDEN NAME

Maggie M. Monroe

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

-

16. SOCIAL  
SECURITY NO.

-

17. INFORMANT

ADDRESS

Parents 2200 Lincoln Ave.

18. 510.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Atelectasis

DUE TO

4 hrs

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Hemorrhage following

DUE TO

T + A.

5 hrs

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

27 June 50

19B. MAJOR FINDINGS OF OPERATION

Tonsillectomy &amp; Adenoidectomy

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office, etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 26 June, 1950, to 27 June, 1950, that I last saw the deceased alive on 27 June, 1950, and that death occurred at 12:00 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Richard M. Garrett M. D.

23B. ADDRESS

Church Home &amp; Hospital

23C. DATE SIGNED

28 June 50

24A. BURIAL, CREMATION,  
REMOVAL (Specify)

24B. DATE

June 30, 1950

24C. NAME OF CEMETERY OR CREMATORY

OAK HAWN CEM.

24D. LOCATION (City, town, or county) (State)

BALTO. Co. Mo.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUN 28 1950

VS 150

William M. Williams

ROLAND H. FISHER DUNDALK

115c Mo.

MEDICAL CERTIFICATION





B-651

50

5706

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

X

50

5706

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HARRY B. BRAMBLE.

2. DATE  
OF  
DEATH

6/27/50.

3. PLACE OF DEATH:

A. Baltimore City, Maryland ✓

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

23 Church Home &amp; Infirmary

4. USUAL RESIDENCE (Where deceased lived, if institution: residence

A. STATE

B. COUNTY

before admission)

MARYLAND BALTO

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

SPARROWS POINT

D. STREET ADDRESS (If rural, give location)

810 E. Street. 5300

C. Length of stay in Baltimore

20 yrs

Yrs.

Mds.

Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

7/24/1882

9. AGE (In years,

last birthday)

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

67 yrs

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

GEN. CARPENTER FORE

10B. KIND OF BUSINESS OR  
INDUSTRY

BETH. STEEL CO.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

William Bramble

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or on leave)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

MRS. EDNA M. BRAMBLE 810 E St

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

DUE TO

Congestive Heart Failure

INTERVAL BETWEEN  
ONSET AND DEATH

2 days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

Pulmonary fibrosis

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from 6/27/1950, to 6/27/1950, that I last saw the  
deceased alive on 6/27/1950, and that death occurred at 10 pm., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUN 28 1950

for William M. M.

ROLAND L. FISHER DUNDALK, MA

3084V

114E

MA

MEDICAL CERTIFICATION

REPUBLIC OF CHINA  
MINISTRY OF NATIONAL DEFENSE  
CENTRAL COMMAND

11-11-1954

11-11-1954

11-11-1954

11-11-1954

11-11-1954

11-11-1954

11-11-1954

11-11-1954

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5707  
Registered No. \_\_\_\_\_

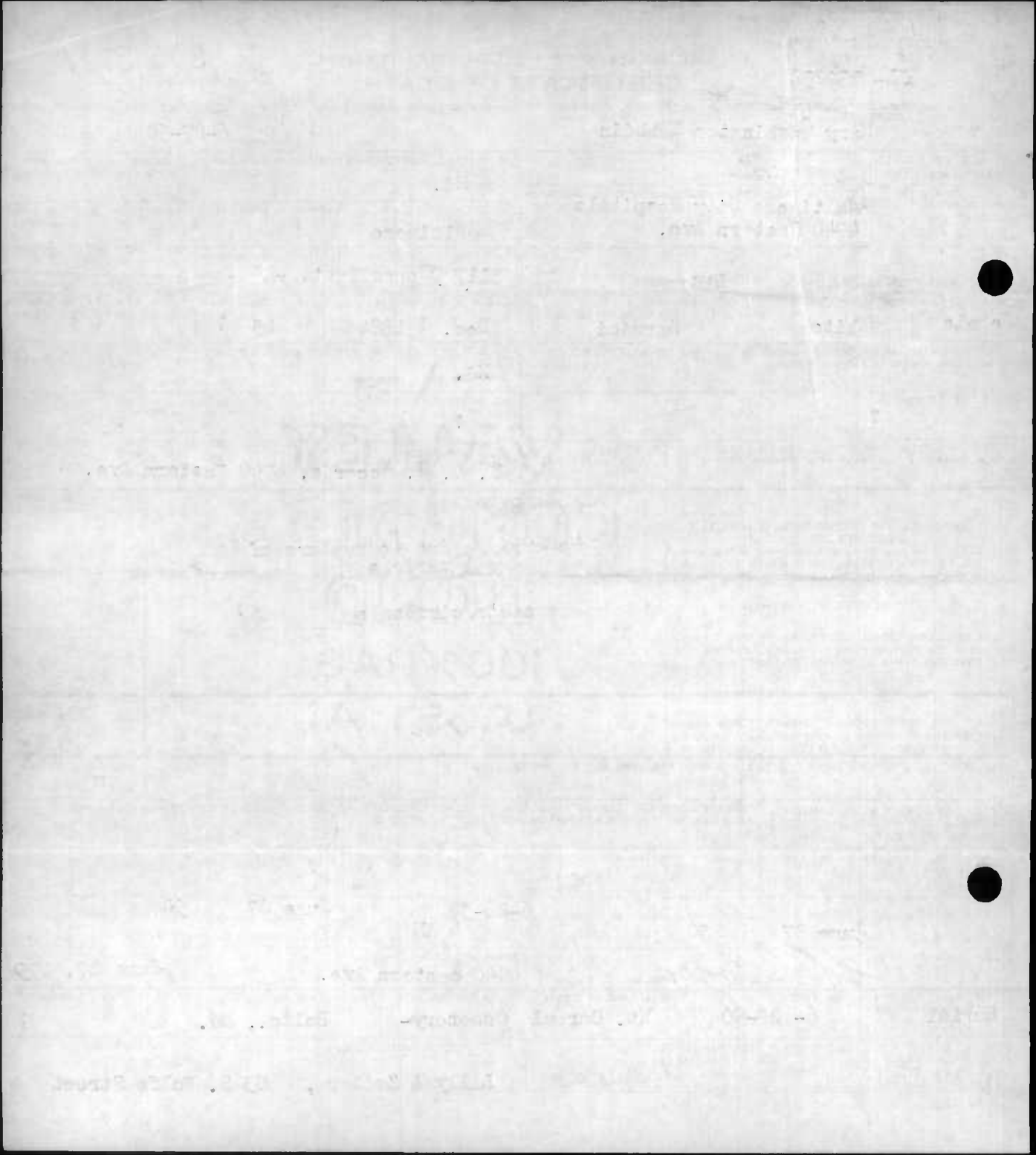
BIRTH NO. \_\_\_\_\_

|  |                                  |   |   |  |  |
|--|----------------------------------|---|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Mary Washington Lambdin</b>                                  |                                  |   | 2. DATE OF DEATH<br><b>6-27-50</b>  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b><br>B. COUNTY _____ |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Baltimore City Hospitals</b><br><b>4940 Eastern Ave.</b> |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>                                |  |  |
| D. STREET ADDRESS (If rural, give location)<br><b>3117 O'Donnell St. -24</b>                           |                                  |   | E. LENGTH OF STAY IN BALTIMORE<br><b>Life</b>   |  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b> | 8. DATE OF BIRTH<br><b>Dec. 7 1884</b>  | 9. AGE (In years last birthday)<br><b>65</b> | 10. Under 1 Year<br>Months: _____ Days: _____<br>11. Under 24 Hours<br>Hours: _____ Min: _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)            |                                  | 10B. KIND OF BUSINESS OR INDUSTRY                                 | 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?   |
| 13. FATHER'S NAME<br><b>?</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>?</b>  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)                                      |                                  | 16. SOCIAL SECURITY NO.   | 17. INFORMANT<br><b>B. C. H. Records, 4940 Eastern Ave.</b>   |  |  |

|   |  |                                  |
|---|--|----------------------------------|
| 18. <b>581.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Hemorrhage due to rupture of esophageal varices</b> |  | INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO<br><b>Laennec's cirrhosis</b>  |  |                                  |
| DUE TO  |  |                                  |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Laennec's cirrhosis</b>  |  |                                  |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |                                  |

|  |   |  |  |   |
|--|---|--|--|---|
| 19A. DATE OF OPERATION<br><b>6-27-50</b>   |   | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |   |
| 22. I hereby certify that I attended the deceased from <b>6-26-50</b> , 19 <b>50</b> , to <b>June 27</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>June 27</b> , 19 <b>50</b> , and that death occurred at <b>4 AM</b> , from the causes and on the date stated above. |   |  |  |   |
| 23A. SIGNATURE<br><i>[Signature]</i>   |   | 23B. ADDRESS<br><b>4940 Eastern Ave.</b>                                 |  | 23C. DATE SIGNED<br><b>June 27, 1950</b>  |

|  |                             |   |  |
|--|-----------------------------|---|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24B. DATE<br><b>6-29-50</b> | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Carmel Cemetery-</b> | 24D. LOCATION (City, town, or county) (State)<br><b>Balto., Md.</b>    |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 28 1950</b>     |                             | REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                       | 25. FUNERAL DIRECTOR<br><b>Lilly &amp; Zeiler, 403 S. Wolfe Street</b> |



P-620

50 5708

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5708  
Registered No.

|   |                           |  |                                   |  |   |
|---|---------------------------|--|-----------------------------------|--|---|
| BIRTH NO.   |                           | 1. NAME OF DECEASED<br>(Type or Print) JULIA ANN PEREGOY   |                                   | 2. DATE OF DEATH<br>June 27, 1950  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                           | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Md.<br>B. COUNTY |                                   |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>1922 Herbert St.   |                           | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 15-04                    |                                   |  |   |
| C. Length of stay in Baltimore  |                           | D. STREET ADDRESS (If rural, give location)<br>1922 Herbert St.  |                                   |  |   |
| 5. SEX<br>female  | 6. COLOR OR RACE<br>white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>widowed   | 8. DATE OF BIRTH<br>Jan. 22, 1879 | 9. AGE (in years last birthday)<br>71                                    | 10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>housewife  |                           | 10B. KIND OF BUSINESS OR INDUSTRY  |                                   | 11. BIRTHPLACE (State or foreign country)<br>Maryland                    |   |
| 12. CITIZEN OF WHAT COUNTRY?  |                           | 13. FATHER'S NAME<br>Edward M. Smith   |                                   | 14. MOTHER'S MAIDEN NAME<br>Ann Temple                                   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>no  |                           | 16. SOCIAL SECURITY NO.<br>no  |                                   | 17. INFORMANT ADDRESS Rd.<br>Mr. Edward J. Peregoy 6911 Windsor Mill     |   |
| 18. 4 yrs. 1<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>Chronic Myocarditis<br>DUE TO<br>Arteriosclerosis<br>(B)<br>DUE TO<br>(C) |                           | CAUSE OF DEATH   |                                   | INTERVAL BETWEEN ONSET AND DEATH<br>yes<br>yes                           |   |
| 19A. DATE OF OPERATION  |                           | 19B. MAJOR FINDINGS OF OPERATION   |                                   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                           |                                   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |                           | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>          |                                   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from June 27/50 to Jan 27/50, that I last saw the deceased alive on June 27/50, and that death occurred at 4:00 p.m., from the causes and on the date stated above.   |                           |  |                                   |  |   |
| 23A. SIGNATURE<br>H. C. Stouck  |                           | 23B. ADDRESS<br>1924 W. ...  |                                   | 23C. DATE SIGNED<br>June 28/50   |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                           | 24B. DATE<br>6/29/50   |                                   | 24C. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cem.                      |   |
| 24D. LOCATION (City, town, or county) (State)<br>Woodlawn, Md.  |                           | 25. FUNERAL DIRECTOR<br>Wm. J. Dickson   |                                   | ADDRESS<br>Wm. J. Dickson, 937 Md.                                       |   |
| DATE RECEIVED BY LOCAL REGISTRAR<br>JUN 28 1950   |                           | REGISTRAR'S SIGNATURE<br>Huntington Williams   |                                   |  |   |



RECEIVED  
FEB 20 1964

U.S. AIR FORCE

OFFICE OF THE

JOINT CHIEFS OF STAFF

WASHINGTON, D.C.

2050 PENTAGON

WASHINGTON, D.C.

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5-142

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

30 5709  
Registered No.

BIRTH NO. 50 5709

1. NAME OF DECEASED  
(Type or Print) *PAULINE SZABLOWSKI*

2. DATE OF DEATH *6-27-50*

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE *MD.* B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
*Baltimore* *27-03*

*2407 Aik'sia Ave.*

D. STREET ADDRESS (If rural, give location)  
*2407 Aik'sia Ave. Aik'sia*

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX *M.* 6. COLOR OR RACE *W.* 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
*married*

8. DATE OF BIRTH *1/26/88* 9. AGE (In years last birthday) *62* 10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
*Housewife*

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME  
*JOHN PEKUT.*

14. MOTHER'S MAIDEN NAME  
*ADELE BRUER.*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)  
*Yes, no or unknown*

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
*William Swode 2407 Aik'sia Ave.*

18. *420.1*  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) *Coronary thrombosis*  
DUE TO  
*Coronary sclerosis*  
(B) *Atherosclerosis*  
DUE TO  
*Hypertensive Cardio-vascular syndrome*

*Sudden*

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *June 19*, 1950, to *June 27*, 1950, that I last saw the deceased alive on *June 26*, 1950, and that death occurred at *12:15 P.m.*, from the causes and on the date stated above.

23A. SIGNATURE  
*H. H. Harford*

23B. ADDRESS  
*4706 Harford Road* 23C. DATE SIGNED  
*6-28-50*

24A. BURIAL, CREMATION, REMOVAL (Specify)  
*Burial*

24B. DATE  
*6/29/50*

24C. NAME OF CEMETERY OR CREMATORY  
*Moreland Memorial*

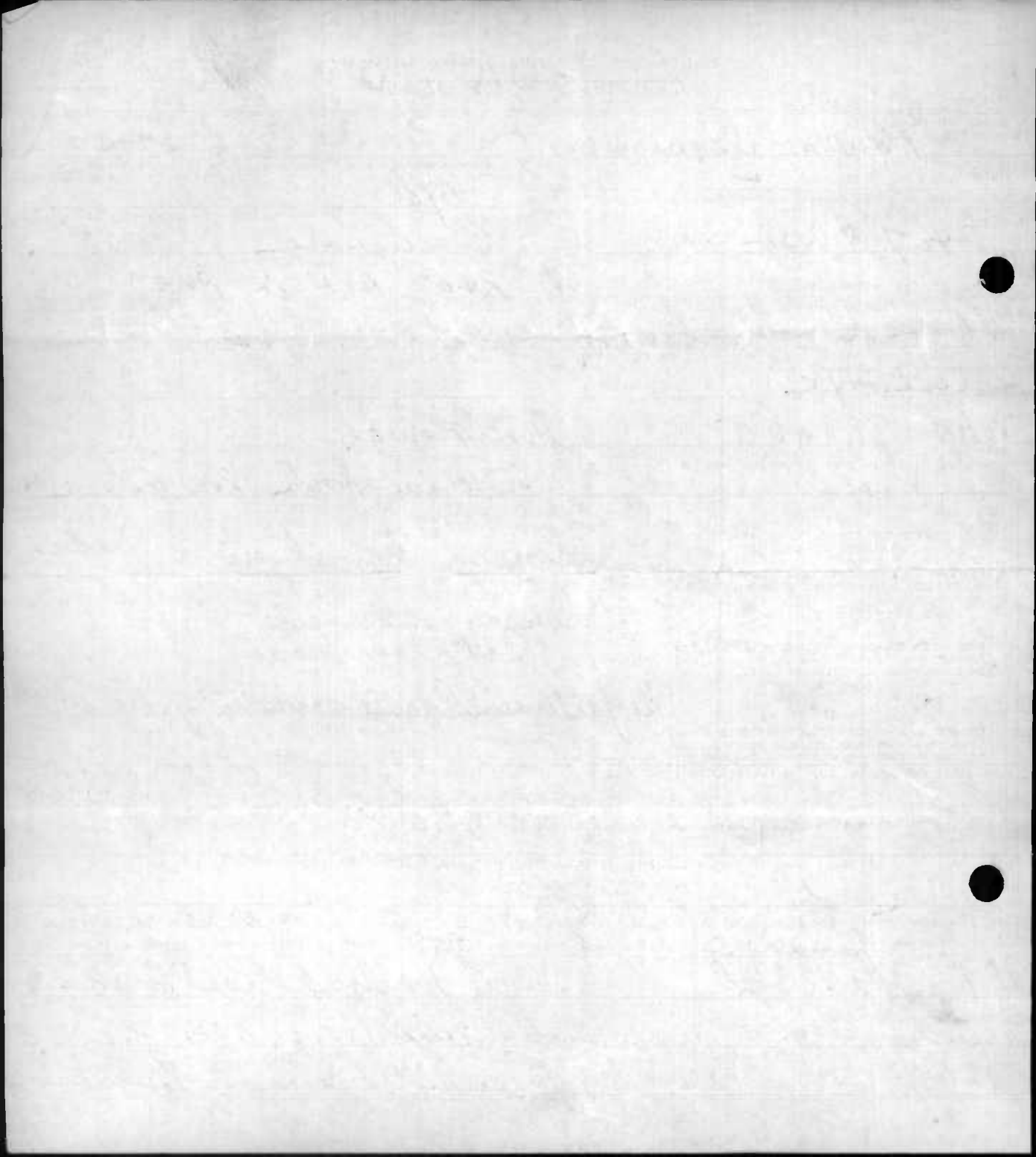
24D. LOCATION (City, town, or county) (State)  
*Taylor Ave. MD.*

DATE RECEIVED BY LOCAL REGISTRAR  
*N 28 1950*

REGISTRAR'S SIGNATURE  
*William Williams, MD*

25. FUNERAL DIRECTOR

ADDRESS  
*Charles W. Jackson, 7340 Henry St.*



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

50 5710  
R 412  
BIRTH NO. \_\_\_\_\_

|   |                                  |   |  |  |  |
|---|----------------------------------|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Mary T. Phillips</i>  |                                  |   | 2. DATE OF DEATH <i>6/27/50</i>  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>18-03</i> |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>36 So. Carlton St.</i>  |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore</i>   |  |  |
| C. Length of stay in Baltimore <i>Life</i>  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><i>36 So. Carlton St.</i>   |  |  |
| 5. SEX<br><i>Female</i>   | 6. COLOR OR RACE<br><i>white</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Married</i> | 8. DATE OF BIRTH<br><i>12/17/1884</i>  |  | 9. AGE (in years last birthday)<br><i>65</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>at Home</i>               | 11. BIRTHPLACE (State or foreign country)<br><i>Baltimore Md.</i>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |
| 13. FATHER'S NAME<br><i>Thomas Ford</i>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><i>Annie Rooney</i>  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)        |                                  | 16. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS<br><i>Thomas H. Phillips 36 So. Carlton St.</i>  |  |  |

|   |  |   |  |
|---|--|---|--|
| 18. <i>420.0</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Arteriosclerotic Heart Disease</i> |  | CAUSE OF DEATH<br>(A) <i>Arteriosclerotic Heart Disease</i><br>DUE TO<br>(B) _____<br>(C) _____ | INTERVAL BETWEEN ONSET AND DEATH<br><i>unknown</i> |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |   |  |

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 19A. DATE OF OPERATION <i>0</i>  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |

22. I hereby certify that I attended the deceased from *Dec 1 1949* to *Jan 5 1950*, that I last saw the deceased alive on *Jan 5 1950*, and that death occurred at *10 AM*, from the causes and on the date stated above.

|  |  |                                    |
|--|--|------------------------------------|
| 23A. SIGNATURE<br><i>Nathan Raesin</i> | 23B. ADDRESS<br><i>206 S. Gilman St.</i> | 23C. DATE SIGNED<br><i>6.27.50</i> |
|--|--|------------------------------------|

|  |                            |  |  |
|--|----------------------------|--|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i> | 24B. DATE<br><i>7/1/50</i> | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Landon Park Cem</i> | 24D. LOCATION (City, town, or county) (State)<br><i>3801 Frederick Ave</i> |
|--|----------------------------|--|--|

|  |   |   |                           |
|--|---|---|---------------------------|
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUN 28 1950</i> | REGISTRAR'S SIGNATURE<br><i>Wilmington Williams, M.D.</i> | 25. FUNERAL DIRECTOR<br><i>John J. Bowman &amp; Son</i> | ADDRESS<br><i>937 St.</i> |
|--|---|---|---------------------------|

MEDICAL CERTIFICATION

NOT A MEDICAL EXAMINER'S CASE

*R. S. Fisher*

M.D.

CHIEF OR ASST. MEDICAL EXAMINER

F-450  
50 5711

50 5711

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mary E. Fallon

2. DATE  
OF  
DEATH

6/27/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

900 Ramsay St.

C. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore 21-02

D. STREET ADDRESS (If rural, give location)

900 Ramsay St.

5. SEX

Female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

at Home

13. FATHER'S NAME

Charles Lusby

8. DATE OF BIRTH

4/17/1893

9. AGE (in years  
last birthday)

57

# Under 1 Year  
Months: Days# Under 24 Hours  
Hours: Min.

11. BIRTH PLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

14. MOTHER'S MAIDEN NAME

Catherine McCarroll

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

William B. Fallon 900 St. Ramsay

18. 584X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Cerebral Thrombosis

INTERVAL BETWEEN  
ONSET AND DEATH

2 1/2 hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Cholecytitis &amp; Arthritis

6 Mo.

(C) DUE TO

Cochefin

3 Mo.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Rectal Prolapse

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 3, 1950, to June 27, 1950, that I last saw the deceased alive on June 26, 1950, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

23A. SIGNATURE

John J. Cowan, Jr.

M. O.

23B. ADDRESS

1933 W. Baltimore St.

23C. DATE SIGNED

6/28/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

6/30/50

24C. NAME OF CEMETERY OR CREMATORY

London Park Cem.

24D. LOCATION (City, town, or county)

3801 Frederick Ave

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

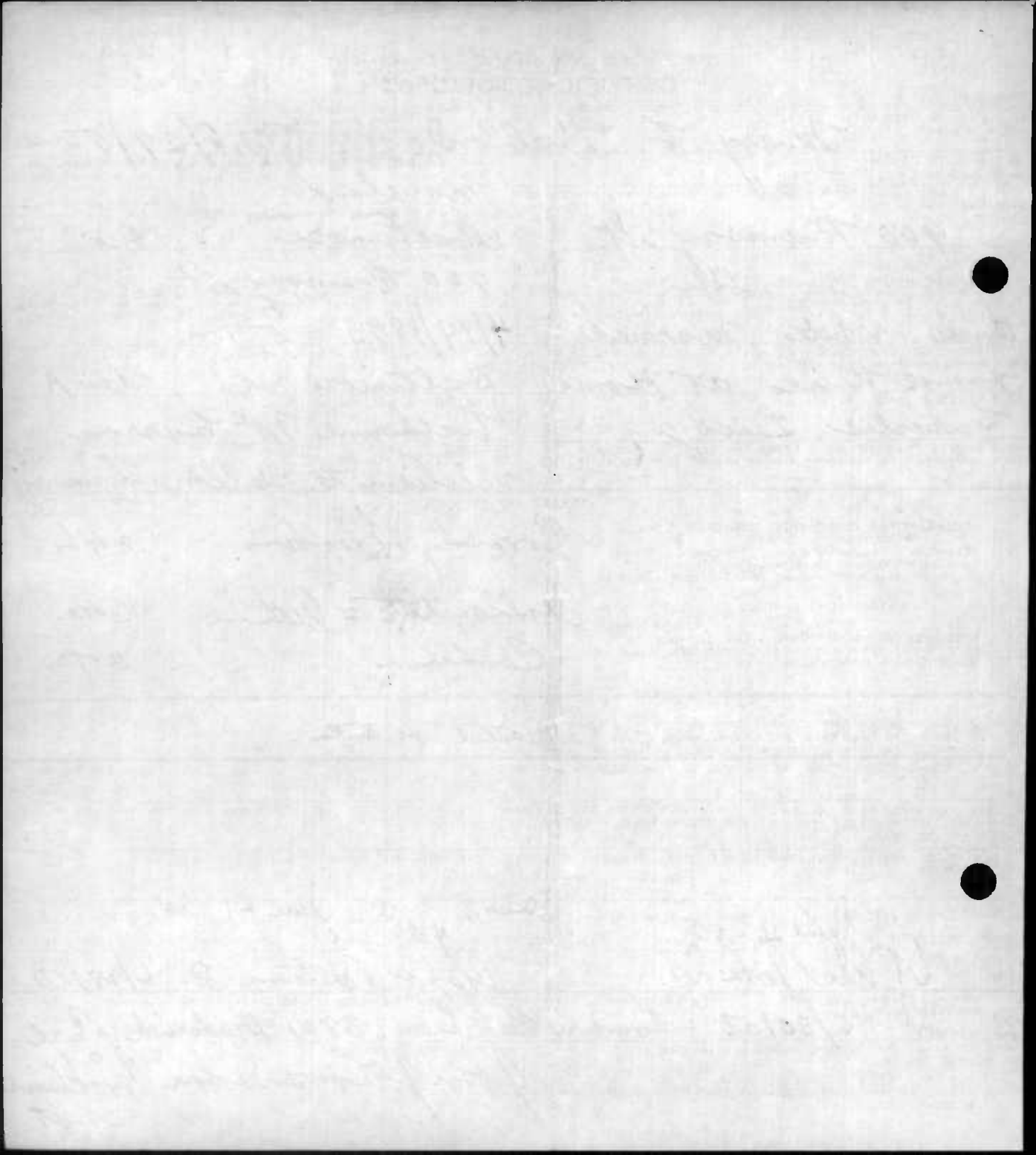
ADDRESS

JUN 28 1950

VS 150

John J. Cowan &amp; Son 940 St. Hollins





H-635 CERTIFICATE CORRECTED 7-13-50

50 5712

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5712

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)Hartenstine  
Jessie Louise Hartenstine2. DATE  
OF  
DEATH

6/28/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland Cecil

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Principio Furnace RURAL

D. STREET ADDRESS (If rural, give location)

5700

C. Length of stay in Baltimore

Yrs. Mos. Days  
4

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

7-30-1875

9. AGE (In years last birthday)

74-75

If Under 1 Year Months Days If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Joseph Smith

14. MOTHER'S MAIDEN NAME

Isabelle Muirhead

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

none

17. INFORMANT

ADDRESS

Mr. Claude Buck Perryville Md

18. 420.1

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial failure &amp; Coronary insufficiency

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive cardiovascular disease  
(C) Arteriosclerotic cardiovascular disease

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

Terminal

over 10 yrs

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-24-1950 to 6-28-1950, that I last saw the deceased alive on 6-28-1950, and that death occurred at 9:25 Am., from the causes and on the date stated above.

23A. SIGNATURE

Marguerite Louise Cadley M.D.

23B. ADDRESS

Maryland General Hosp.

23C. DATE SIGNED

6/28/50

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

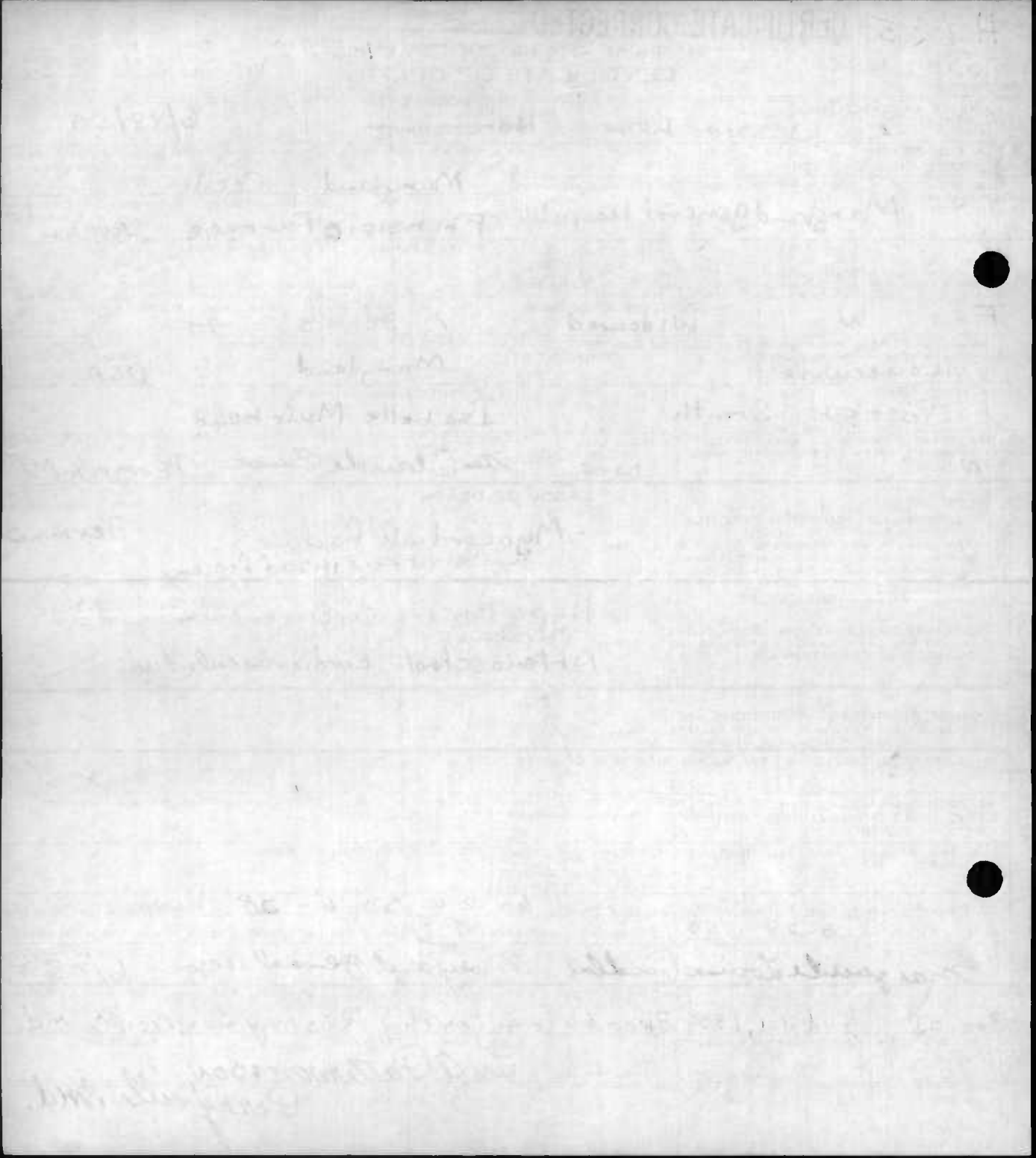
25. FUNERAL DIRECTOR

ADDRESS

JUN 28 1950

Marguerite Louise Cadley

Lee A. Patterson &amp; Son, Perryville, Md.



F-640

50 5713

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5713

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

SAMUEL P

FERRELL

2. DATE  
OF  
DEATH

June 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore City

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTIONGood SAMARITAN  
Hospital4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

3-91

D. STREET ADDRESS (If rural, give location)

1616 E. Pratt St.

C. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Mar. 14.

9. AGE (In years  
last birthday)

69

10. Under 1 Year  
Months: Days

10 32

11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Sma. Georgia

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT

Cora. Page

ADDRESS

1616 E. Pratt St.

18. 420.0 I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

## CAUSE OF DEATH

CHRONIC MYOCARDITIS AND

(A) MYOCARDIAL DEGENERATION  
DUE TO CHRONIC DECOMPENSATION(B) ARTERIOSCLEROTIC HEART  
Disease

(C) Generalized Arteriosclerosis ?

INTERVAL BETWEEN  
ONSET AND DEATH

8 weeks

?

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from MAY 12, 1950, to June 27, 1950, that I last saw the  
deceased alive on June 26, 1950, and that death occurred at 6:25 A.M., from the causes and on the date stated above.

23A. SIGNATURE

William N. Borden

M. D.

23B. ADDRESS

2030 W. Fayette St

23C. DATE SIGNED

6/27/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

July 1 1950

24C. NAME OF CEMETERY OR CREMATORY

Mount Carmel

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wm. N. Borden

25. FUNERAL DIRECTOR

Wm. N. Borden 3125 Highland

ADDRESS

98899

937

UNITED STATES OF AMERICA  
DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

WATER RESOURCES DIVISION  
SALT LAKE CITY, UTAH

WATER RESOURCES DIVISION  
SALT LAKE CITY, UTAH

WATER RESOURCES DIVISION  
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SALT LAKE CITY, UTAH

WATER RESOURCES DIVISION  
SALT LAKE CITY, UTAH

D- 242  
50 5714BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5714  
Registered No.

BIRTH NO.

|   |                                  |  |  |  |   |
|---|----------------------------------|--|--|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>DOUGLASS, CHARLES</b>   |                                  |  | 2. DATE OF DEATH<br><b>6/27/50</b>   |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>md.</b> B. COUNTY |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Provident</b>   |                                  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore, md.</b>                  |  |   |
| C. Length of stay in Baltimore  |                                  |  | D. STREET ADDRESS (If rural, give location)<br><b>3417 Payton ave PATON</b>  |  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Negro</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)          | 8. DATE OF BIRTH<br><b>3/7/1863</b>  |  | 9. AGE (in years, last birthday)<br><b>86</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Trainer</b> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Horse racing</b> | 11. BIRTHPLACE (State or foreign country)<br><b>Charlottesville, Va.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |
| 13. FATHER'S NAME<br><b>Unknown</b>   |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)      |                                  | 16. SOCIAL SECURITY NO.                                  | 17. INFORMANT<br><b>Mrs. Maggie Washington</b>   |  |   |
|   |                                  |  | ADDRESS<br><b>3417 Paton Ave</b>   |  |   |

|   |                |                                  |
|---|----------------|----------------------------------|
| 18. <b>420.0</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Anterosebrotic Heart Disease</b><br>DUE TO<br><b>Pulmonary Edema + Congestion</b> | CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>(B)</b>  |                |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                |                                  |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 19A. DATE OF OPERATION<br><b>6/29/50</b>   |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>6/19</b> , 19 <b>50</b> , to <b>6/27</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>6/26</b> , 19 <b>50</b> , and that death occurred at <b>8:35</b> A. m., from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE<br><b>John H. Holmes</b>  |  | 23B. ADDRESS<br><b>Provident Hosp.</b>  |  | 23C. DATE SIGNED<br><b>6/28/50</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>6/29/50</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary</b>                            |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>  |  | 25. FUNERAL DIRECTOR<br><b>Holland's Funeral Home</b>   |  |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 28 1950</b>   |  | REGISTRAR'S SIGNATURE<br><b>William M. Hollander</b>  |  | ADDRESS<br><b>1631 Druid Hill Ave</b>   |  |

937



CERTIFICATE OF DEATH

100



B-600

50 5715

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5715  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Hattie Berry (Barry)

2. DATE  
OF  
DEATH

June 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

1612 W. Fayette St.

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

19-02

C. Length of stay in Baltimore

10

Yrs.

Mos.

Days

D. STREET ADDRESS (If rural, give location)

1612 W. Fayette St.

5. SEX

Female

6. COLOR OR RACE

C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Jan. 18, 1910

9. AGE (In years last birthday)

40

10 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Greenville, S.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Samuel

14. MOTHER'S MAIDEN NAME

Lula Nora

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

No.

Belton Service, 1612 W. Fayette St.

18.

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic myocarditis

1 year

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Chronic myocarditis

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)

INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/1, 1949, to 6/26, 1950, that I last saw the deceased alive on 6/25, 1950, and that death occurred at 10 a. m., from the causes and on the date stated above.

23A. SIGNATURE

M. O.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

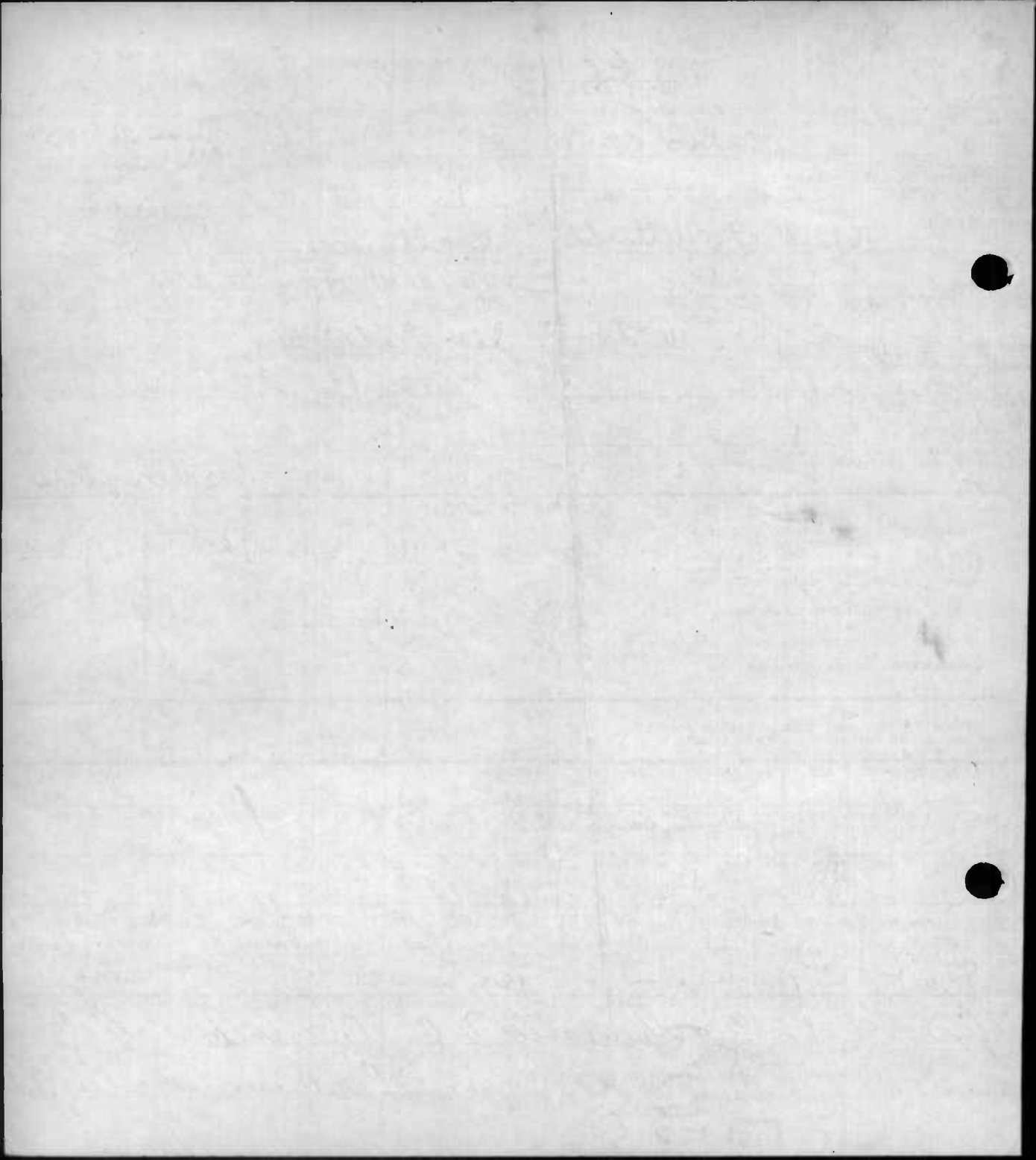
(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



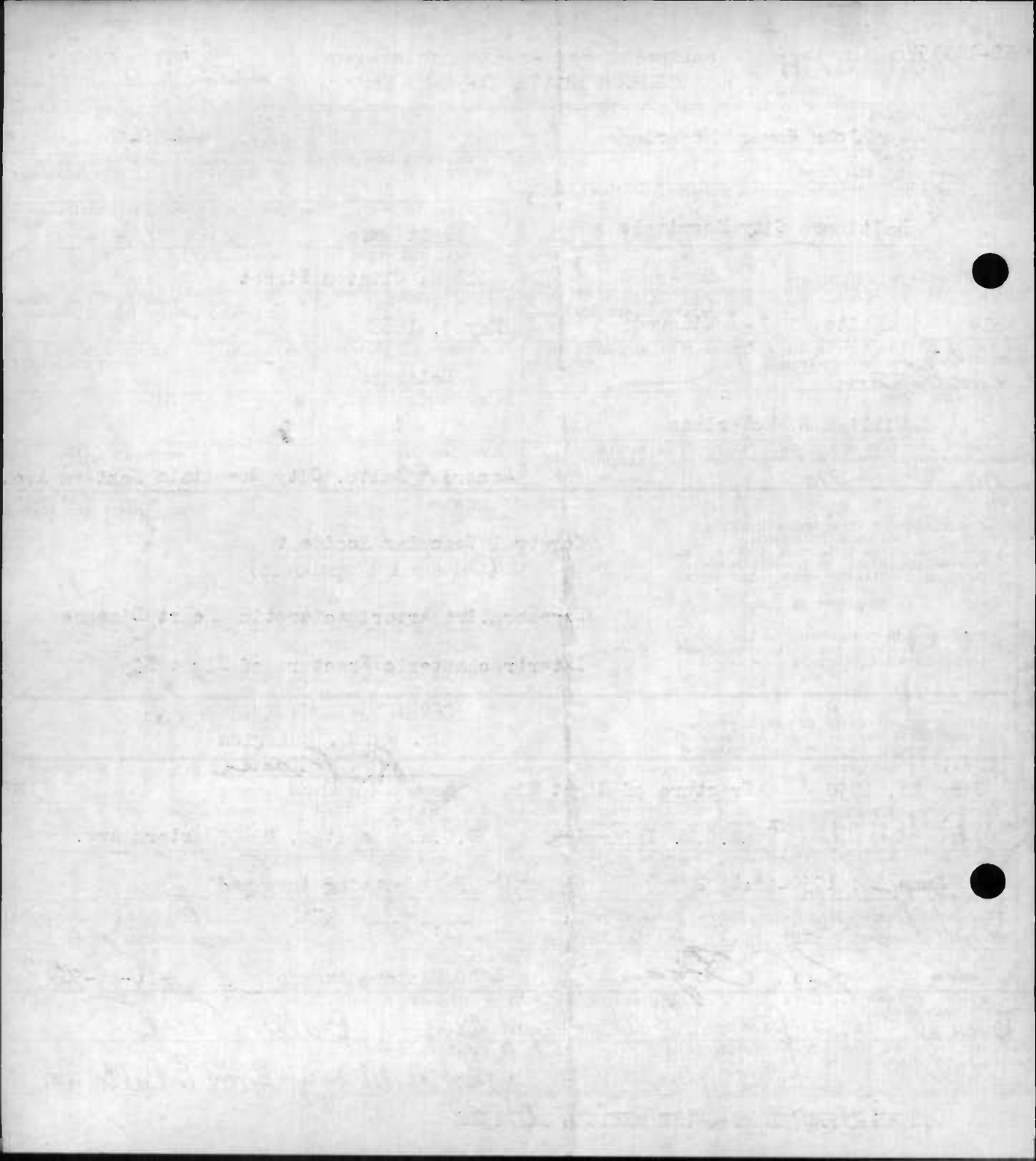
M-216  
ES-129330 5716

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

550 5716  
Registered No.

|  |                                  |   |   |   |  |
|--|----------------------------------|---|---|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>John Howard McFarlane</b>  |                                  |   | 2. DATE OF DEATH<br><b>6-26-50</b>  |   |  |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Ma</b> B. COUNTY |   |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>Baltimore City Hospitals</b>  |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 26-10</b>                |   |  |
| C. Length of stay in Baltimore <b>40 Yrs</b>   |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>112 N. Clinton Street</b>   |   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b>   | 8. DATE OF BIRTH<br><b>May 3, 1868</b>  | 9. AGE (in years last birthday)<br><b>82</b>  | 10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>unknown</b>  |                                  | 10B. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (State or foreign country)<br><b>Delaware</b>  |   | 12. CITIZEN OF WHAT COUNTRY?                                 |
| 13. FATHER'S NAME<br><b>William R. McFarlane</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>?</b>  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>no</b>   |                                  | 16. SOCIAL SECURITY NO. <b>870</b>  | 17. INFORMANT ADDRESS <b>4940 Records* Balto. City Hospitals Eastern Ave.</b>   |   |  |
| 18. <b>E 904.7</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cerebral Vascular Accident (Cerebral thrombosis)</b><br>DUE TO<br>(A) <b>Cerebral Vascular Accident (Cerebral thrombosis)</b><br>(B) <b>Degenerative Arteriosclerotic Heart Disease</b><br>DUE TO<br>(C) <b>Intertrochanteric Fracture of Right Hip</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. |                                  |   | INTERVAL BETWEEN ONSET AND DEATH  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                                  |   | CERTIFICATION APPROVED BY<br><b>Dr. Wm. G. Hellrich</b><br><b>RS Fisher M.D.</b><br>CHIEF OR ASST. MEDICAL EXAMINER.  |   |  |
| 19A. DATE OF OPERATION<br><b>June 21, 1950</b>   |                                  | 19B. MAJOR FINDINGS OF OPERATION<br><b>Fracture of Right Hip</b>  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>  |                                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>B.C.H. Infirmary</b> |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>B.C.H. Hospital, 4940 Eastern Ave.</b> |  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br><b>June 16, 1950-10:40 P.M.</b>   |                                  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?<br><b>Fell getting into bed</b>  |  |
| 22. I hereby certify that I attended the deceased from <b>6-2</b> <sup>1950</sup> , to <b>6-26</b> <sup>1950</sup> , that I last saw the deceased alive on <b>6-26</b> <sup>1950</sup> , and that death occurred at <b>11:50 P.M.</b> , from the causes and on the date stated above.  |                                  |   |   |   |  |
| 23A. SIGNATURE<br><b>J.S. Boyen M.D.</b>   |                                  | 23B. ADDRESS<br><b>4940 Eastern Avenue</b>  |   | 23C. DATE SIGNED<br><b>6-26-50</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 24B. DATE<br><b>6/30/50</b>   |   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cem.</b>  |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md</b>  |                                  | 24E. NAME OF CEMETERY OR CREMATORY<br><b>Balto. Md</b>  |   | 24F. LOCATION (City, town, or county) (State)<br><b>Balto. Md</b>   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>N 28 1950</b>   |                                  | REGISTRAR'S SIGNATURE<br><b>William Williams, M.D.</b>  |   | 25. FUNERAL DIRECTOR<br><b>John A. Moran</b>  |  |
| VS 150<br><b>N-820.1</b>   |                                  | ADDRESS<br><b>3000 E. Balto. St.</b>  |   | 186a  |  |

TO BE APPROVED BY CHIEF MEDICAL EXAMINER



W-326

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5717  
Registered No.

|  |                               |  |                                 |
|--|-------------------------------|--|---------------------------------|
| BIRTH NO. 50 5717  |                               | 2. DATE OF DEATH JUN 27 1950   |                                 |
| 1. NAME OF DECEASED (Type or Print) <i>George Whitaker</i>   |                               | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Fla</i> B. COUNTY <i>V-08</i> |                                 |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                               | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>St Petersburg</i>                               |                                 |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>JOHNS HOPKINS HOSPITAL</i>   |                               | D. STREET ADDRESS (If rural, give location)<br><i>909 8th Ave St</i>   |                                 |
| C. Length of stay in Baltimore <i>5 days</i>   |                               | Yrs. Mos. Days   |                                 |
| 5. SEX <i>Male</i>   | 6. COLOR OR RACE <i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>   | 8. DATE OF BIRTH <i>9-22-10</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Officer Salvation Army - Religious</i> |                               | 9. AGE (in years last birthday) <i>40</i>  |                                 |
| 10B. KIND OF BUSINESS OR INDUSTRY  |                               | 11. BIRTHPLACE (State or foreign country) <i>Arkansas</i>  |                                 |
| 13. FATHER'S NAME <i>Att Whitaker</i>  |                               | 12. CITIZEN OF WHAT COUNTRY? <i>US</i>   |                                 |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><i>No</i>   |                               | 16. SOCIAL SECURITY NO. <i>No</i>  |                                 |
| 17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i>  |                               | ADDRESS  |                                 |

|   |  |  |
|---|--|--|
| 18. 331X I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Antitubercular hemorrhage</i> | CAUSE OF DEATH<br>(A) <i>Antitubercular hemorrhage</i><br>DUE TO | INTERVAL BETWEEN ONSET AND DEATH<br><i>1 day</i> |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B) _____<br>DUE TO<br>(C) _____  |  |  |

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| 19A. DATE OF OPERATION <i>✓</i>  |  | 19B. MAJOR FINDINGS OF OPERATION   |   | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) <i>6:22-1950</i>   | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |  |  |
| 22. I hereby certify that I attended the deceased from <i>6-22-1950</i> to <i>6-27-1950</i> , that I last saw the deceased alive on <i>6-27-1950</i> , and that death occurred at <i>11:30</i> m., from the causes and on the date stated above. |  |  |   |  |  |
| 23A. SIGNATURE <i>Herbert C. Johnson</i> M. D.   |  | 23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>                               |   | 23C. DATE SIGNED <i>6/28/50</i>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>  | 24B. DATE <i>6/30/50</i>   | 24C. NAME OF CEMETERY OR CREMATORY <i>West View</i>                      | 24D. LOCATION (City, town, or county) (State) <i>Atlanta - Ga</i> |  |  |
| DATE RECEIVED BY LOCAL REGISTRAR   |  | REGISTRAR'S SIGNATURE <i>Wilmington Williams, M.D.</i>                   |   | 25. FUNERAL DIRECTOR <i>Stewart Morris</i> ADDRESS <i>Balto</i>                  |  |

N 73-150

V6894

83a



George Washington  
St. Louis  
1793

James M. Smith  
St. Louis  
1793

James M. Smith  
St. Louis  
1793

T-512

50 5718

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5718  
Registered No.

|  |                           |  |   |
|--|---------------------------|--|---|
| BIRTH NO.  |                           | 2. DATE OF DEATH<br>June 27, 1950  |   |
| 1. NAME OF DECEASED<br>(Type or Print)<br>FLORELLA THOMPSON  |                           | 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>00 3407 Fairview Ave.                                       |                           | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE Missouri<br>B. COUNTY V-22 |   |
| C. CITY OR TOWN<br>St. Louis   |                           | D. STREET ADDRESS (If rural, give location)  |   |
| C. Length of stay in Baltimore 12 years<br>Yrs. Mos. Days  |                           | 8. DATE OF BIRTH<br>MAY 22, 1874   |   |
| 5. SEX<br>Female   | 6. COLOR OR RACE<br>White | 9. AGE (In years last birthday)<br>76 years  | If Under 1 Year<br>Months: Days<br>If Under 24 Hours<br>Hours: Min. |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Single  |                           | 10. KIND OF BUSINESS OR INDUSTRY<br>School Teacher   |   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Retired |                           | 11. BIRTHPLACE (State or foreign country)<br>Montgomery, Missouri  |   |
| 13. FATHER'S NAME<br>Richard S. Thompson   |                           | 12. CITIZEN OF WHAT COUNTRY?<br>USA  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br>NO                                |                           | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT<br>Mrs. Harry A. Jones - 3407 Fairview Av. City  |                           | ADDRESS  |   |

|   |   |   |
|---|---|---|
| 18. 331X<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>DUE TO | CAUSE OF DEATH<br>(A) Hemiplegia (Right)<br>(Cerebral hemorrhage) | INTERVAL BETWEEN ONSET AND DEATH<br>1 day |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO  | (B) Arteriosclerosis<br>Hypertension                              | 3 years                                   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>DUE TO   |   |   |

|   |   |  |
|---|---|--|
| 19A. DATE OF OPERATION<br>0   | 19B. MAJOR FINDINGS OF OPERATION  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>INJURY   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |
| 22. I hereby certify that I attended the deceased from 1-1, 1949 to 6-27, 1950 that I last saw the deceased alive on 6-27, 1950, and that death occurred at 6 A.M., from the causes and on the date stated above. |   |  |
| 23A. SIGNATURE<br>Howard J. Warner, M.D.  | 23B. ADDRESS<br>2404 Garrison Way   | 23C. DATE SIGNED<br>6-28-50  |

|   |  |  |  |
|---|--|--|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial | 24B. DATE<br>June 30, 1950                           | 24C. NAME OF CEMETERY OR CREMATORY<br>Belle Fontaine Cemetery      | 24D. LOCATION (City, town, or county) (State)<br>St. Louis, Missouri |
| DATE RECEIVED BY LOCAL REGISTRAR<br>JUN 28 1950     | REGISTRAR'S SIGNATURE<br>Christington Williams, M.D. | 25. FUNERAL DIRECTOR<br>Stewart & Mowen Company, 108 W. North Ave. | ADDRESS  |

VAM

31 50 5719

50 5719

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Alice Wilkerson Oldfield</b>  |  |  | 2. DATE OF DEATH<br><b>6 - 28 - 50</b>   |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>none</b> |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>1700 Linden Avenue</b> |  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>   |  |  |
| D. STREET ADDRESS (If rural, give location)<br><b>1700 Linden Ave.</b>  |  |  | 5. SEX <b>female</b>   |  |  |
| 6. COLOR OR RACE <b>white</b>   |  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>widowed</b>  |  |  |
| 8. DATE OF BIRTH<br><b>2-9-64</b>   |  |  | 9. AGE (In years last birthday)<br><b>86</b>   |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>   |  |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Harford County, Md.</b>   |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>   |  |  |
| 13. FATHER'S NAME<br><b>Thomas M. Wilkinson</b>   |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Osborn</b>  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)                               |  |  | 16. SOCIAL SECURITY NO.  |  |  |
| 17. INFORMANT<br><b>Mrs. Edna O. Williams-1513 Pentridge Rd.</b>  |  |  | ADDRESS  |  |  |

|  |  |   |
|--|--|---|
| 18. <b>331X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cerebral hemorrhage</b><br>DUE TO<br><b>Arteriosclerosis</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 months</b> |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                |  |   |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 19A. DATE OF OPERATION<br><b>0</b>   |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br><b>Nov 27, 1950</b>   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>Nov 27, 1950</b> , to <b>28 June, 1950</b> , that I last saw the deceased alive on <b>27 June, 1950</b> , and that death occurred at <b>4 a.m.</b> , from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE<br><b>Dr. Proctor</b>   |  | 23B. ADDRESS<br><b>104 W. Madison St.</b>   |  | 23C. DATE SIGNED  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>   |  | 24B. DATE<br><b>7 - 1 - 50</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion Cemetery</b>                      |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Fountain Green, Md.</b>  |  | 25. FUNERAL DIRECTOR<br><b>Joseph T. Foster</b>   |  | ADDRESS<br><b>Bel Air, Md.</b>  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 28 1950</b>   |  | REGISTRAR'S SIGNATURE<br><b>Washington Williams</b>   |  | VS 150  |  |

MEDICAL CERTIFICATION

83a

DECLARATION OF DEPENDENCY

STATE OF CALIFORNIA

COUNTY OF LOS ANGELES

I, the undersigned, do hereby certify that

the following person is dependent upon me

and is entitled to the benefits of the

State of California.

Witness my hand and seal this

day of

19

at

California.

Notary Public for the State of California

My commission expires

at

California.

Notary Public for the State of California

My commission expires

at

California.

Notary Public for the State of California

My commission expires

at

California.

160  
50 5720

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5720

Registered No. \_\_\_\_\_

|   |                                  |  |   |   |                                  |
|---|----------------------------------|--|---|---|----------------------------------|
| BIRTH NO. _____   |                                  | 1. NAME OF DECEASED<br>(Type or Print) <i>HELMMA COOPER</i>  |   | 2. DATE OF DEATH<br><i>6/28/50</i>  |                                  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> |   |   |                                  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>Baltimore Len Hosp</i>  |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Belvedere Beach</i>                                       |   |   |                                  |
| C. Length of stay in Baltimore  |                                  | D. STREET ADDRESS (If rural, give location)<br><i>5200</i>   |   |   |                                  |
| 5. SEX<br><i>Female</i>   | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Married</i>  | 8. DATE OF BIRTH<br><i>Jan. 4, 1914</i> | 9. AGE (In years last birthday)<br><i>36</i>  | 10. Under 1 Year<br>Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>At Home</i>  |   | 11. BIRTH PLACE (State or foreign country)<br><i>Baltimore MD</i>                   |                                  |
| 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |                                  | 13. FATHER'S NAME<br><i>Harley Holschlag</i>   |   | 14. MOTHER'S MAIDEN NAME<br><i>Myrtle Miller</i>                                    |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><i>No</i>  |                                  | 16. SOCIAL SECURITY NO.<br><i>None</i>   |   | 17. INFORMANT<br><i>John Cooper, Belvedere Beach</i>                                |                                  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>201X I</i>  |                                  | CAUSE OF DEATH<br>(A) <i>Hodgkins Disease</i><br>DUE TO  |   | INTERVAL BETWEEN ONSET AND DEATH<br><i>5/23/50 to 6/28/50</i>                       |                                  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><i>II</i>   |                                  | (B) _____<br>DUE TO  |   |   |                                  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                                  | (C) _____<br>DUE TO  |   |   |                                  |
| 19A. DATE OF OPERATION<br><i>0</i>  |                                  | 19B. MAJOR FINDINGS OF OPERATION   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |                                  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                    |   | 21F. HOW DID INJURY OCCUR?  |                                  |
| 22. I hereby certify that I attended the deceased from <i>5/23/50</i> , 19 <i>50</i> , to <i>6/28/50</i> , 19 <i>50</i> , that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above. |                                  |  |   |   |                                  |
| 23A. SIGNATURE<br><i>Ed. J. [Signature]</i>   |                                  | 23B. ADDRESS<br><i>50 Balt. Len Hosp</i>   |   | 23C. DATE SIGNED<br><i>6/28/50</i>  |                                  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |                                  | 24B. DATE<br><i>7/1/50</i>   |   | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Cathman</i>                                |                                  |
| 24D. LOCATION (City, town, or county) (State)<br><i>Cathman Baltimore MD</i>  |                                  | 24E. NAME OF CEMETERY OR CREMATORY<br><i>Cathman</i>   |   | 24F. LOCATION (City, town, or county) (State)<br><i>Cathman Baltimore MD</i>        |                                  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUN 29 1950</i>  |                                  | REGISTRAR'S SIGNATURE<br><i>Wm. J. [Signature]</i>   |   | 25. FUNERAL DIRECTOR<br><i>Wm. J. [Signature]</i>                                   |                                  |
|   |                                  |  |   | ADDRESS<br><i>1217 E. Cal St</i>  |                                  |



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# CERTIFICATE CORRECTED

## BALTIMORE CITY HEALTH DEPARTMENT

### CERTIFICATE OF DEATH

Registered No. 50 5721

BIRTH NO. 5721

1. NAME OF DECEASED (Type or Print) George Cain (CANN) 2. DATE OF DEATH June 28, 1950

3. PLACE OF DEATH: A. Baltimore City, Maryland 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

5. FULL NAME OF (If not in hospital or institution, give street address or location) Provident Hospital 6. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-06

7. LENGTH OF STAY IN BALTIMORE 20 Yrs. Mos. Days 8. STREET ADDRESS (If rural, give location) 2409 Lovegrove St.

9. SEX Male 10. COLOR OR RACE Colored 11. SINGLE, MARRIED, (WIDOWED) DIVORCED (Specify) 12. DATE OF BIRTH 12-23-1900 13. AGE (In years last birthday) 49 14. Under 1 Year Months: Days 15. Under 24 Hours Hours: Min.

16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SANITATOR 17. KIND OF BUSINESS OR INDUSTRY APT. HOUSE 18. BIRTHPLACE (State or foreign country) CHESTER TOWN M.D. 19. CITIZEN OF WHAT COUNTRY? U.S.A.

20. FATHER'S NAME MOSES CANN 21. MOTHER'S MAIDEN NAME CHARITY BUTLER.

22. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) 23. SOCIAL SECURITY NO. 240-07-1833 25. INFORMANT ANNIE WOODS - PINE ST.

18. 443X I CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Hypertensive Cardiovascular Disease

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) INJURY 21e. INJURY OCCURRED WHILE AT ☐ NOT WHILE ☐ WORK AT WORK 21f. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23a. SIGNATURE Stanley K. Quinlan M.D. 23b. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ 23c. DATE SIGNED June 28, 1950

24a. BURIAL CREMATION, REMOVAL (Specify) Burial 24b. DATE 7/1/50 24c. NAME OF CEMETERY OR CREMATORY Mt. Calvary 24d. LOCATION (City, town, or county) (State) Cedar Hill Md.

DATE RECEIVED BY LOCAL REGISTRAR 7/9/1950 REGISTRAR'S SIGNATURE W. H. Hulstead 25. FUNERAL DIRECTOR W. H. Hulstead - 918 931

V.S. 151 74081 Remind Hill ave.

MEDICAL CERTIFICATION



# CERTIFICATE CORRECTED

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 5722  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

TURNER, JAMES

2. DATE  
OF  
DEATH

6-23-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

University Hospital

C. Length of stay in Baltimore

1919

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

City

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

19-01

D. STREET ADDRESS (If rural, give location)

1512 - Mulberry St

5. SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

Mar. 24/1892

9. AGE (In years  
last birthday)

58

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Kitchen man

10B. KIND OF BUSINESS OR  
INDUSTRY

Elkridge Club

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Alex Turner

14. MOTHER'S MAIDEN NAME

Laura?

15. WAS DECEASED  
(Yes, no or unknown)

no

EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)

None

16. SOCIAL  
SECURITY NO.

218-05-1694

17. INFORMANT

Mary Turner - Mulberry St

18. 443X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A)

Cerebral Hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Hypertensive CVD

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Bronchopneumonia

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-17-1950, to 6-23-1950, that I last saw the deceased alive on 6-22-1950, and that death occurred at 7 P.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

W. A. Halstead

M. D.

Univ. Hosp.

6-26-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Shipped

24B. DATE

6/29/50

24C. NAME OF CEMETERY OR CREMATORY

Wilson N.C.

24D. LOCATION (City, town, or county)

A. A. Co., Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

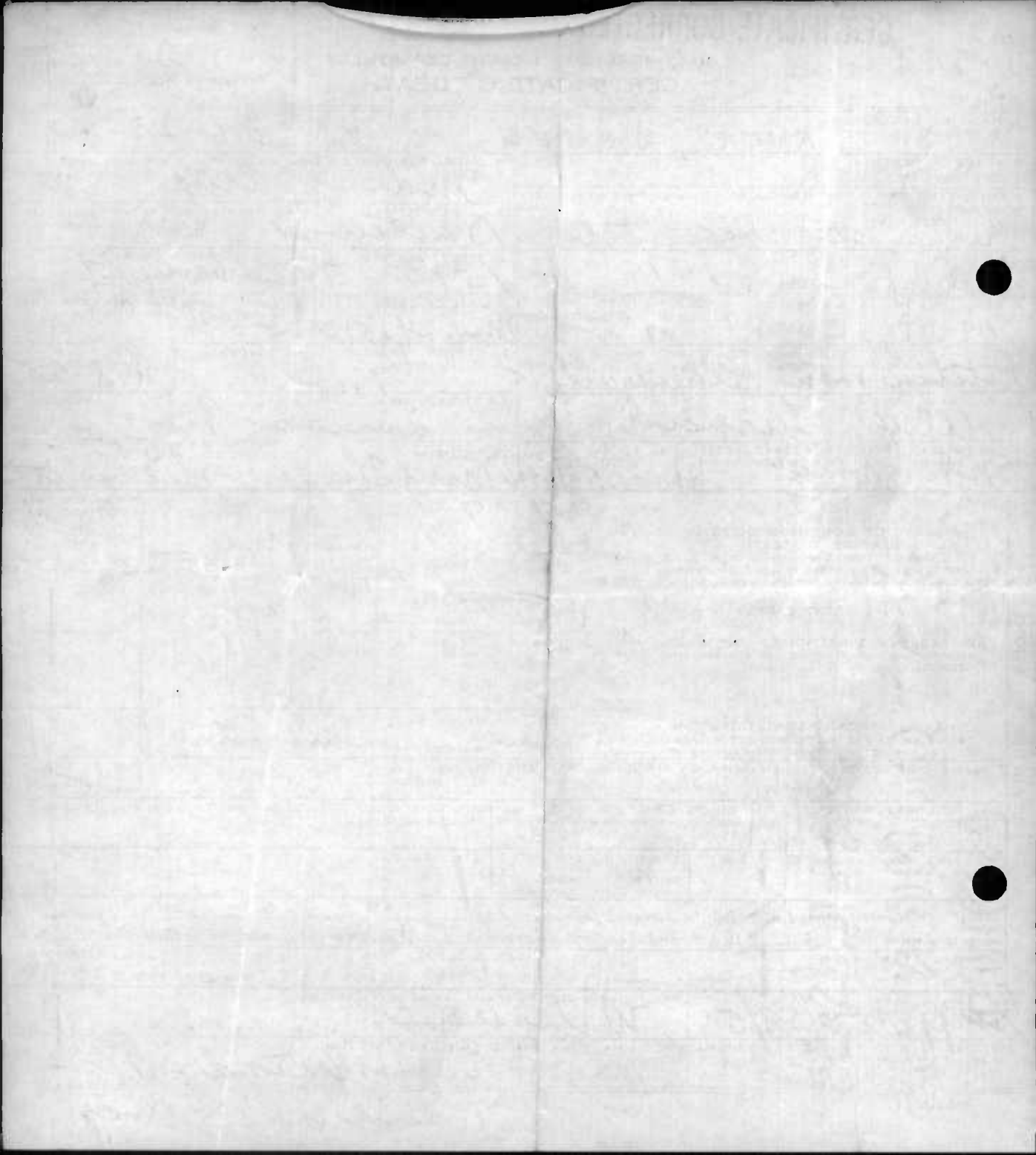
REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

W. A. Halstead - 918 -

ADDRESS



325

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5723

BIRTH NO. 5723

1. NAME OF DECEASED  
(Type or Print)

Annie M. Watkins.

2. DATE  
OF  
DEATH

June 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

1913 Cutaw Place

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Aug 2, 1870

9. AGE (In years;  
last birthday)

79 80

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR  
INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Pa

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Pearl M. Hardesty, 1312 W. 41st St.

18. 181X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

carcinoma of bladder

12 months

DUE TO

## ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK22. I hereby certify that I attended the deceased from June 1, 1950, to June 27, 1950, that I last saw the  
deceased alive on June 27, 1950 and that death occurred at 7:15 Pm., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

2431 Maryland Ave;

6/28/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUN 29 1950

Wilmington Williams, M.D.

Paul C. Schmeider, 365-11 Chestnut Ave.



2431 Mid. Ave

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 5724

430  
50 5724  
BIRTH NO.

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Minerva Welty</i>  |                                  | 2. DATE OF DEATH<br><i>6-26-50</i>   |  |
| 3. PLACE OF DEATH:<br>A. <i>Baltimore City, Maryland</i>   |                                  | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <i>Md</i><br>B. COUNTY |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>South Balto. Gen Hosp</i>                                    |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 22-01</i>                   |  |
| C. Length of stay in Baltimore   |                                  | D. STREET ADDRESS (If rural, give location)<br><i>210 E. Churchill St</i>  |  |
| 5. SEX<br><i>Female</i>  | 6. COLOR OR RACE<br><i>white</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Married</i>  | 8. DATE OF BIRTH<br><i>July 12, 1907</i>     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>none</i> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>none</i>   | 9. AGE (In years last birthday)<br><i>42</i> |
| 13. FATHER'S NAME<br><i>Charles R. Smith</i>   |                                  | 14. MOTHER'S MAIDEN NAME<br><i>Helara Lindsay</i>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><i>-</i>                              |                                  | 16. SOCIAL SECURITY NO.<br><i>-</i>  |  |
| 17. INFORMANT<br><i>Mr James Welty</i>   |                                  | ADDRESS<br><i>210 E. Churchill</i>   |  |

|   |   |
|---|---|
| 18. <i>171X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | CAUSE OF DEATH<br>(A) <i>Generalized carcinoma of cervix</i><br>DUE TO <i>Carcinoma of cervix</i><br><br>(B) _____<br>DUE TO _____<br><br>(C) _____ |
|---|---|

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 19A. DATE OF OPERATION<br><i>6-29-50</i>     |  | 19B. MAJOR FINDINGS OF OPERATION<br><i>Carcinoma of cervix</i>  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |

22. I hereby certify that I attended the deceased from *5-29-50*, to *6-26*, 19*50* that I last saw the deceased alive on *6-26-50*, and that death occurred at *10:10 p.m.*, from the causes and on the date stated above.

|                                     |                              |                  |
|-------------------------------------|------------------------------|------------------|
| 23A. SIGNATURE<br><i>W. A. Bire</i> | 23B. ADDRESS<br><i>M. D.</i> | 23C. DATE SIGNED |
|-------------------------------------|------------------------------|------------------|

|  |  |  |   |
|--|--|--|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i> | 24B. DATE<br><i>6-30-50</i>                | 24C. NAME OF CEMETERY OR CREMATORY<br><i>A. Josephs Cemetery</i> | 24D. LOCATION (City, town, or county) (State)<br><i>Martinsburg, W. Va.</i> |
| DATE RECEIVED BY LOCAL REGISTRAR                           | REGISTRAR'S SIGNATURE<br><i>W. A. Bire</i> | 25. FUNERAL DIRECTOR<br><i>John Foley Inc</i>                    | ADDRESS<br><i>715 Light</i>   |

JUN 29 1950

48a

MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

State of New York, County of \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_ 19\_\_\_\_

at \_\_\_\_\_

\_\_\_\_\_

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Mr. Mullen

4

655  
5726BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5726  
Registered No.

|  |                                    |  |   |
|--|------------------------------------|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Fannie R. Freeman</i>  |                                    | 2. DATE OF DEATH<br><i>June 26, 1950</i>   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>1920 Riggs Ave</i>  |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>1920 Riggs Ave Baltimore</i><br>B. COUNTY |   |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>00</i>   |                                    | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 16-04</i>   |   |
| 6. Length of stay in Baltimore<br>Yrs. Mos. Days   |                                    | D. STREET ADDRESS (If rural, give location)<br><i>1920 Riggs Ave</i>   |   |
| 7. SEX<br><i>Female</i>  | 8. COLOR OR RACE<br><i>Colored</i> | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>married</i>  | 10. DATE OF BIRTH<br><i>Sept 22, 1902</i> |
| 11. AGE (in years last birthday)<br><i>47</i>  |                                    | 12. H Under 1 Year Months: Days H Under 24 Hours Hours: Min.   |   |
| 13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>   |                                    | 14. KIND OF BUSINESS OR INDUSTRY   |   |
| 15. BIRTHPLACE (State or foreign country)<br><i>Norfolk, Va</i>  |                                    | 16. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>  |   |
| 17. FATHER'S NAME<br><i>Fred Miller</i>  |                                    | 18. MOTHER'S MAIDEN NAME<br><i>Ritner King</i>   |   |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)<br><i>no</i>  |                                    | 20. SOCIAL SECURITY NO.  |   |
| 21. INFORMANT<br><i>William R. Freeman</i>   |                                    | 22. ADDRESS<br><i>1920 Riggs Ave</i>   |   |
| 23. CAUSE OF DEATH<br>I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>(A) <i>Uremia; Ruptured Aortic Aneurysm</i><br>DUE TO<br>(B) <i>Hypertension</i><br>DUE TO<br>(C) <i>Nephrosclerosis</i><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                                    |  |   |
| 24. DATE OF OPERATION<br><i>0</i>  |                                    | 25. MAJOR FINDINGS OF OPERATION  |   |
| 26. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                    |  |   |
| 27. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                                    | 28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   |
| 29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                                    |  |   |
| 30. TIME (Month) (Day) (Year) (Hour) INJURY  |                                    | 31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   |
| 32. HOW DID INJURY OCCUR?  |                                    |  |   |
| 33. I hereby certify that I attended the deceased from <i>June 22, 1950</i> , to <i>June 26, 1950</i> , that I last saw the deceased alive on <i>June 26, 1950</i> , and that death occurred at <i>4:30 p.m.</i> , from the causes and on the date stated above.   |                                    |  |   |
| 34. SIGNATURE<br><i>Samuel H. Curtis, Jr.</i>  |                                    | 35. ADDRESS<br><i>1745 Pennsylvania Ave N.W.</i>   |   |
| 36. DATE SIGNED<br><i>6/28/50</i>  |                                    |  |   |
| 37. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |                                    | 38. DATE<br><i>June 29, 1950</i>   |   |
| 39. NAME OF CEMETERY OR CREMATORY<br><i>National Cemetery</i>  |                                    | 40. LOCATION (City, town, or county) (State)<br><i>Baltimore Md.</i>   |   |
| 41. DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUN 29 1950</i>   |                                    | 42. REGISTRAR'S SIGNATURE<br><i>Wilmington Williams</i>  |   |
| 43. FUNERAL DIRECTOR<br><i>Miss Katie R. Williams</i>  |                                    | 44. ADDRESS<br><i>Schweizer St</i>   |   |





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5727  
Registered No. \_\_\_\_\_

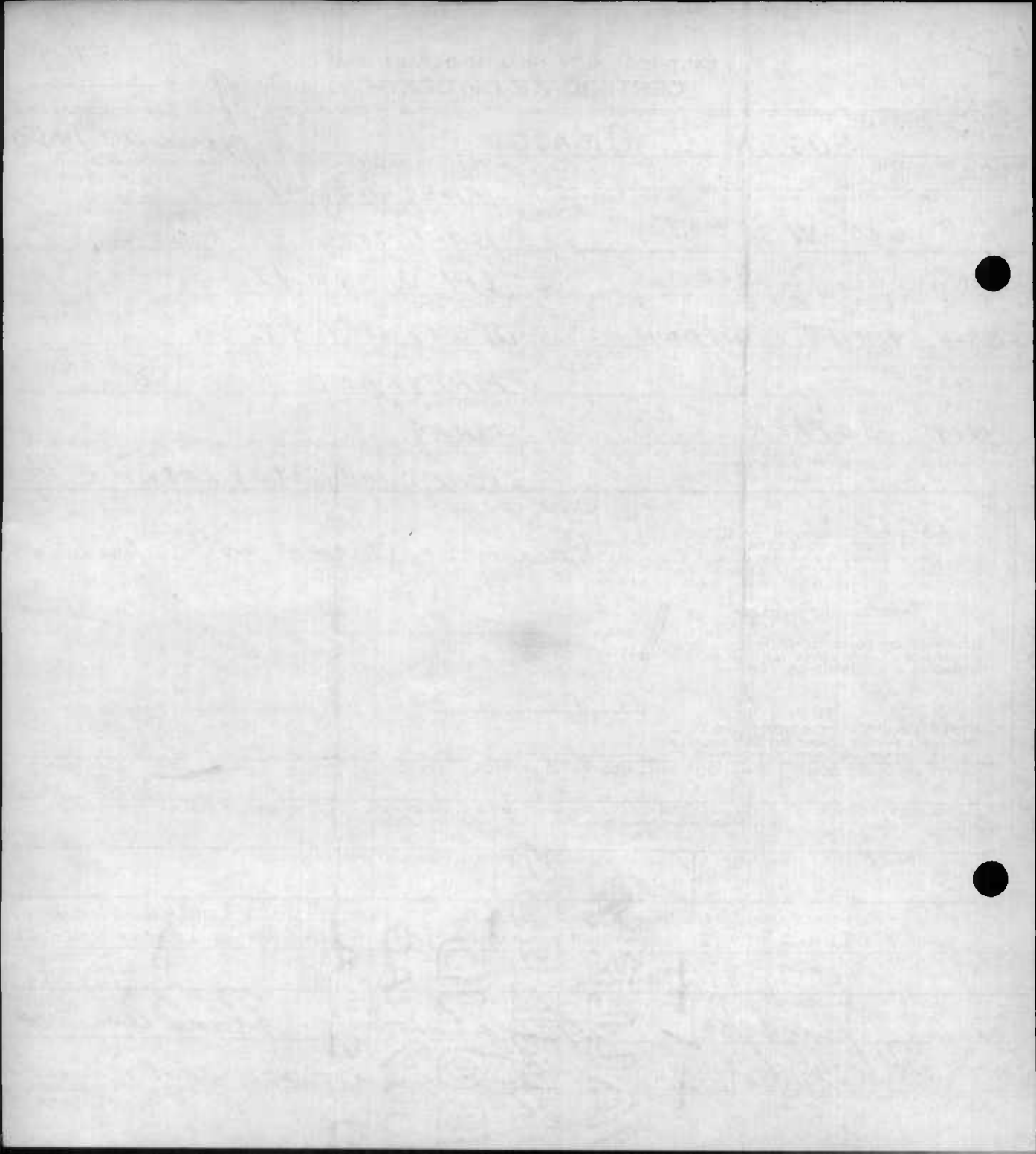
620  
50 5727  
BIRTH NO. \_\_\_\_\_

|  |                                  |   |  |  |   |
|--|----------------------------------|---|--|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>SUSAN C. CRAIG.</b>  |                                  |   |  | 2. DATE OF DEATH<br><b>June 27, 1950</b>   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY _____ |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>614 W 36<sup>th</sup> ST</b>                                 |                                  |   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTIMORE 13-07</b>                               |   |
| C. Length of stay in Baltimore <b>LIFE</b>   |                                  |   |  | D. STREET ADDRESS (If rural, give location)<br><b>614 W 36<sup>th</sup> ST.</b>  |   |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>WIDOW</b> |  | 8. DATE OF BIRTH<br><b>DEC 17-1857 92</b>  | 9. AGE (In years last birthday) <b>92</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>NONE</b> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>                   |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |   |
| 13. FATHER'S NAME<br><b>WM BUTLER</b>  |                                  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)  |                                  | 16. SOCIAL SECURITY NO.   |  | 14. MOTHER'S MAIDEN NAME<br><b>MARY ?</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)                        |                                  |   |  | 17. INFORMANT ADDRESS<br><b>IRENE CRUE - 2938 KESWICK RD.</b>  |   |

|   |   |  |
|---|---|--|
| 18. <b>176X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Carcinoma (vaginal wall)</b><br>DUE TO |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>About 6 mo.</b>                   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>(A) DUE TO</b>   |   |  |
| <b>(B) DUE TO</b>   |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>(C) DUE TO</b>  |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>  | 19B. MAJOR FINDINGS OF OPERATION  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |

22. I hereby certify that I attended the deceased from **Jan 1940** to **Jun 27, 1950**, that I last saw the deceased alive on **Jun. 27, 1950**, and that death occurred at **3:10 p. m.**, from the causes and on the date stated above.

|  |   |  |
|--|---|--|
| 23A. SIGNATURE<br><b>Wm N. McFaul Jr.</b>                  | 23B. ADDRESS<br><b>840 W. 36<sup>th</sup> ST</b>  | 23C. DATE SIGNED<br><b>6/28/50</b>   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24B. DATE<br><b>June 30/50</b>                    | 24C. NAME OF CEMETERY OR CREMATORY<br><b>St. Marys Hospital - Plant Care 240</b> |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 29 1950</b>     | REGISTRAR'S SIGNATURE<br><b>Justin E. Donovan</b> | 25. FUNERAL DIRECTOR ADDRESS<br><b>3818 Plant Care</b>                           |

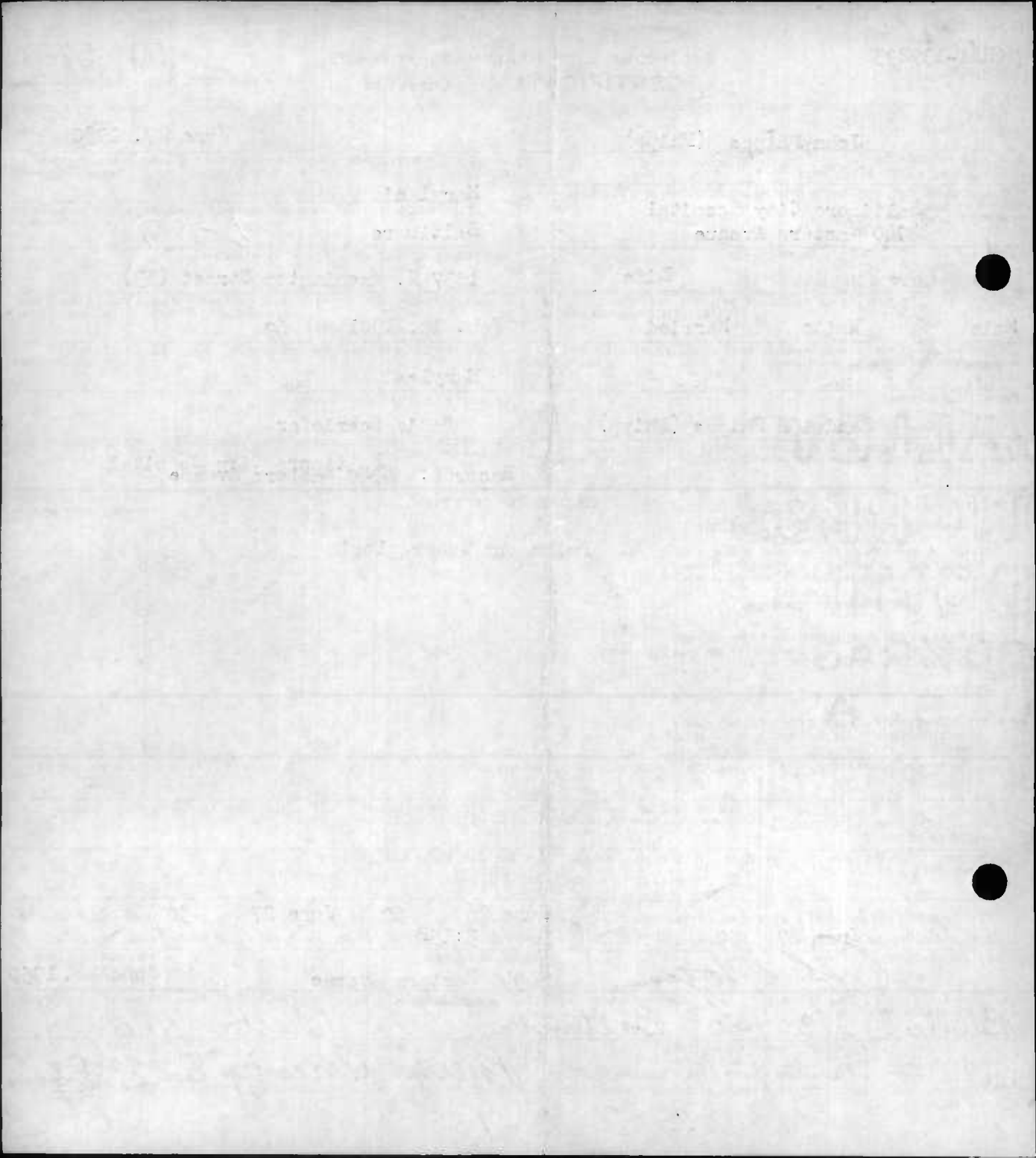


120  
108-139233  
5728  
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5728  
Registered No.

|  |                                  |   |   |   |   |
|--|----------------------------------|---|---|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>John Phipps (Phipp)</b>  |                                  |   | 2. DATE OF DEATH <b>June 27, 1950</b>   |   |   |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>Baltimore</b> |   |   |
| 5. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>Baltimore City Hospital</b><br><b>4940 Eastern Avenue</b> |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>  |   |   |
| 6. Length of stay in Baltimore <b>Life</b>   |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>1237 N. Washington Street (13)</b>  |   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b> | 8. DATE OF BIRTH<br><b>Feb. 14, 1901</b>  | 9. AGE (In years last birthday)<br><b>49</b>  | 10. Under 1 Year<br>Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HUCKSTER</b>                                       |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>SELF</b>                  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                        |   |
| 13. FATHER'S NAME<br><b>Randolph Phipps (Phipp)</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Sadie Schriefer</b>  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT <b>Baltimore City Hospital</b><br><b>Records: 4940 Eastern Avenue</b> |   |

|  |  |                                  |
|--|--|----------------------------------|
| 18. <b>002X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Pulmonary Tuberculosis</b><br>DUE TO<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  | INTERVAL BETWEEN ONSET AND DEATH |
|--|--|----------------------------------|

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 19A. DATE OF OPERATION <b>✓</b>   |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>June 26, 1950</b> , to <b>June 27, 1950</b> , that I last saw the deceased alive on <b>June 27, 1950</b> , and that death occurred at <b>8:15 P. M.</b> , from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE<br><b>Ch. Hogan</b>  |  | 23B. ADDRESS<br>M. D. <b>4940 Eastern Avenue</b>  |  | 23C. DATE SIGNED<br><b>June 28, 1950</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>6/30/50</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore</b>                              |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b>  |  | 24E. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore</b>  |  | 24F. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b>                  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 29 1950</b>  |  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b>   |  | 25. FUNERAL DIRECTOR<br><b>Philip Herwig Sons</b>                                   |  |



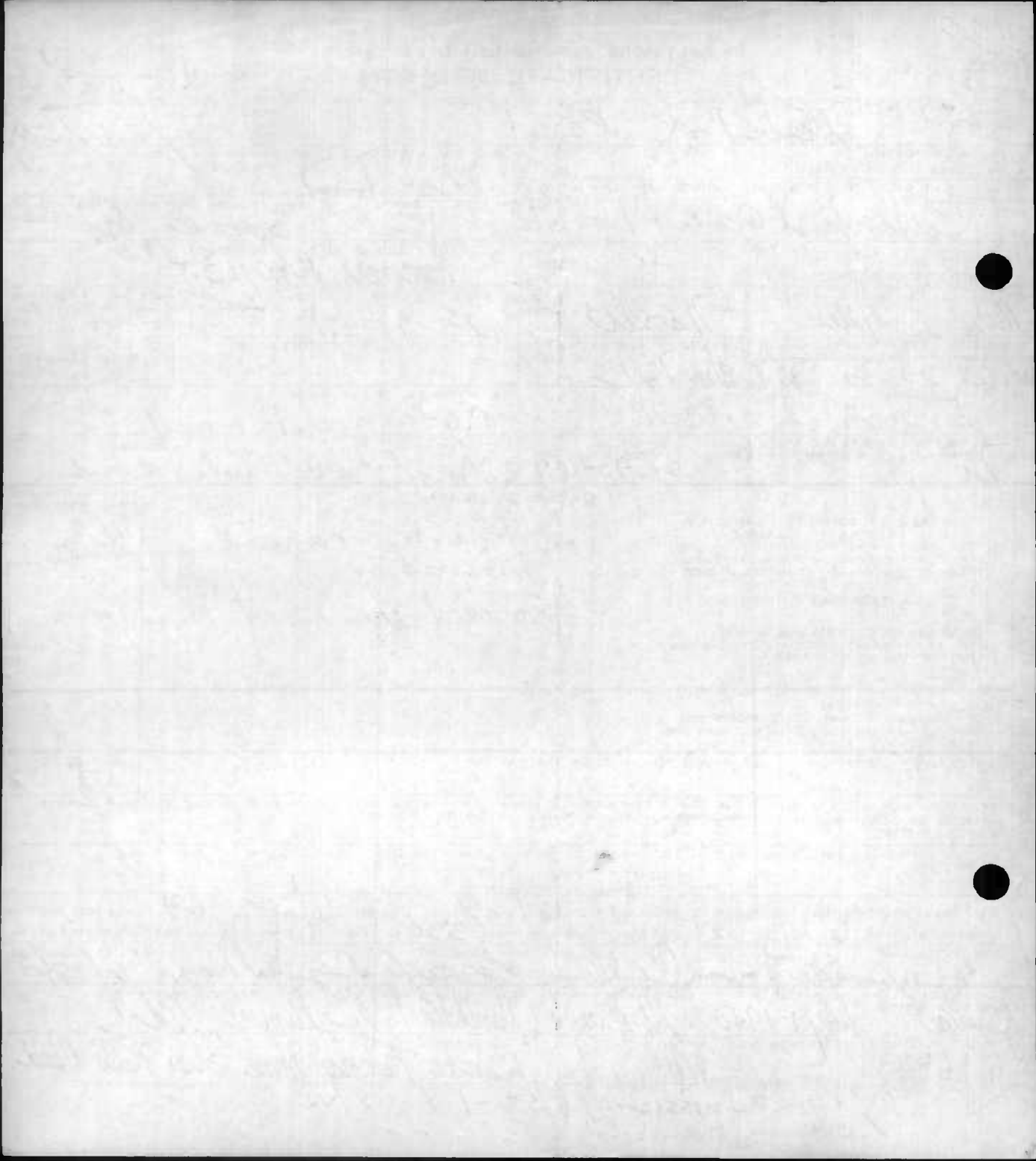
300  
0 5729  
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

X Registered No. 50 5729

|  |                                  |  |                                       |
|--|----------------------------------|--|---------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Herbert R Reed</i>   |                                  | 2. DATE OF DEATH <i>6/28/50</i>  |                                       |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  | 4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>Anne Arundel</i>  |                                       |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><i>Maryland General Hospital</i>   |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Rural? Dorsey Md</i>  |                                       |
| C. Length of stay in Baltimore<br>Yrs. Mos. Days   |                                  | D. STREET ADDRESS (If rural, give location)<br><i>Hanover Box 103 E 5200</i>   |                                       |
| 5. SEX<br><i>Male</i>  | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Married</i>  | 8. DATE OF BIRTH<br><i>12-19-1891</i> |
| 9. AGE (in years last birthday)<br><i>58</i>   |                                  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Overseer</i>  |                                       |
| 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Cotton Mill</i>  |                                  | 11. BIRTHPLACE (State or foreign country)  |                                       |
| 12. CITIZEN OF WHAT COUNTRY?   |                                  | 13. FATHER'S NAME<br><i>Enoch L Reed</i>   |                                       |
| 14. MOTHER'S MAIDEN NAME<br><i>Roseanna Parrnell</i>   |                                  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>No</i>  |                                       |
| 16. SOCIAL SECURITY NO.<br><i>216-10-1811</i>  |                                  | 17. INFORMANT ADDRESS<br><i>May E. Reed wife as above</i>  |                                       |
| 18. <i>420.0</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br>(A) <i>Anterior myocardial infarction</i><br>DUE TO<br>(B) <i>Arteriosclerotic heart disease</i><br>DUE TO<br>(C)<br>INTERVAL BETWEEN ONSET AND DEATH<br><i>4 days?</i><br><i>years</i> |                                  | 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                                       |
| 19A. DATE OF OPERATION<br><i>0</i>   |                                  | 19B. MAJOR FINDINGS OF OPERATION   |                                       |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                                       |
| 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  |                                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                                       |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                                       |
| 21F. HOW DID INJURY OCCUR?   |                                  | 22. I hereby certify that I attended the deceased from <i>6/24</i> , 19 <i>50</i> to <i>6/28</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>6/27</i> , 19 <i>50</i> , and that death occurred at <i>3:30 A.M.</i> , from the causes and on the date stated above. |                                       |
| 23A. SIGNATURE<br><i>Maryanne Louise Cadden</i>  |                                  | 23B. ADDRESS<br><i>Maryland General Hosp.</i>  |                                       |
| 23C. DATE SIGNED<br><i>6/28/50</i>   |                                  | 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                                       |
| 24B. DATE<br><i>July 1-1950</i>  |                                  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>St. Mary's (Baltimore)</i>  |                                       |
| 24D. LOCATION (City, town, or county)<br><i>Baltimore, Md.</i>   |                                  | 24E. FUNERAL DIRECTOR<br><i>Burgess Funeral Home 3631 Falls Road.</i>  |                                       |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUN 29 1950</i>   |                                  | REGISTRAR'S SIGNATURE<br><i>William W. Williams</i>  |                                       |
| VS 150   |                                  | previous admission <i>4/6/50 - 4-18/50</i><br>coronary insufficiency <i>316 X 8</i>  |                                       |

937





323  
50 5730BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5730  
Registered No.

|   |                                  |   |   |   |   |
|---|----------------------------------|---|---|---|---|
| BIRTH NO.   |                                  | 1. NAME OF DECEASED<br>(Type or Print)<br><b>Mrs. Elizabeth B. Stocksdale</b>   |   | 2. DATE<br>OF<br>DEATH<br><b>June 27, 1950</b>                                      |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY  |   |   |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>00 3835 Keswick Road</b>  |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 13-07</b>  |   |   |   |
| C. Length of stay in Baltimore<br><b>50 years</b>   |                                  | D. STREET ADDRESS (If rural, give location)<br><b>3803 Roland Avenue</b>  |   |   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widow</b>   | 8. DATE OF BIRTH<br><b>July 1, 1872</b> | 9. AGE (In years last birthday)<br><b>77</b>  | 10. Under 1 Year<br>Months: Days<br>11. Under 24 Hours<br>Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>At Home</b>   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                        |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |                                  | 13. FATHER'S NAME<br><b>Henry Zumbrun</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary C. Baum</b>                                     |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br><b>Howard B. Stocksdale</b>  |   |
| 18. ADDRESS<br><b>3835 Keswick Road</b>   |                                  | 19. CAUSE OF DEATH<br><b>I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Carcinoma of Hepatic flexure of</b><br><b>the colon with Metastasis to Liver &amp; Kidney</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>16 mos.</b> |   |   |   |
| 18. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B)<br>(C)  |                                  | 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |   |   |   |
| 19A. DATE OF OPERATION<br><b>Feb. 13th, 1950</b>  |                                  | 19B. MAJOR FINDINGS OF OPERATION<br><b>Carcinoma of Colon &amp; Duodenum</b>  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |   |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>INJURY   |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I hereby certify that I attended the deceased from <b>Feb. 19th, 1949</b> , to <b>June 27th, 1950</b> , that I last saw the deceased alive on <b>June 26th, 1950</b> , and that death occurred at <b>8:15 A. M.</b> , from the causes and on the date stated above. |                                  |   |   |   |   |
| 23A. SIGNATURE<br><b>J. H. Wilson</b>   |                                  | 23B. ADDRESS<br><b>617 W. 40th St</b>   |   | 23C. DATE SIGNED<br><b>6/28/50</b>  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 24B. DATE<br><b>June 30, 1950</b>   |   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge</b>                            |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Pikesville, Maryland</b>  |                                  | 25. FUNERAL DIRECTOR<br><b>Burgee Funeral Home</b>  |   | 25. ADDRESS<br><b>3631 Falls Road</b>   |   |

MEDICAL CERTIFICATION

RECEIVED  
JAN 16 1977  
FBI  
NEW YORK

460

5731

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5731

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Miss Frances Miller

2. DATE  
OF  
DEATH

6/27/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Church Home &amp; Hospital

C. Length of stay in Baltimore

35

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

S.

8. DATE OF BIRTH

Sept. 18, 1865

9. AGE (In years,  
last birthday)

84

10. Under 1 Year  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR  
INDUSTRY

—

13. FATHER'S NAME

John J. H. Miller

11. BIRTHPLACE (State or foreign country)

Ballo.

12. CITIZEN OF  
WHAT COUNTRY?

USA

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT

ADDRESS

Mrs. Ethel Pulney Lane

18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Subacute Lymphatic Leukemia Year

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Arteriosclerotic Heart Disease Year

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)

INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/1/50, to 6/27, 1950, that I last saw the  
deceased alive on 6/27, 1950 and that death occurred at 11:40 P. m., from the causes and on the date stated above.

23A. SIGNATURE

Robert E. Enos

M. O.

23B. ADDRESS

Harold Home &amp; Hosp.

23C. DATE SIGNED

6/27/50.

24A. BURIAL, CREMA-  
TION (Specify)

24B. DATE

6/30/50

24C. NAME OF CEMETERY OR CREMATORY

Harold Ridge

24D. LOCATION (City, town, or county) (State)

Pikesville, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Thos. J. Zickner &amp; Sons, Baltimore, Md.

VS 150

937 Md.

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH, MASSACHUSETTS

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5732BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

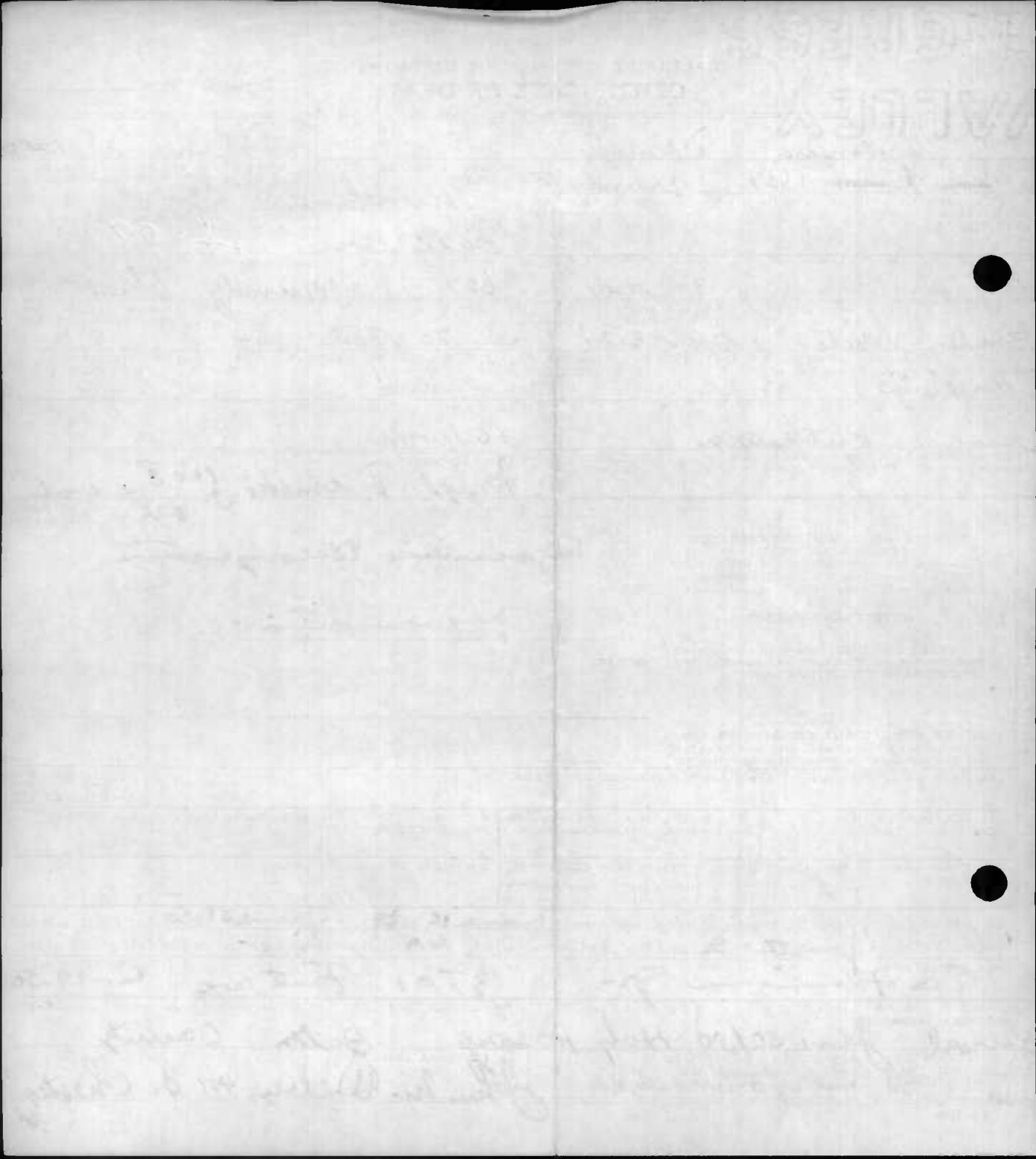
Registered No. \_\_\_\_\_

50 5732

|  |                                  |   |   |   |  |
|--|----------------------------------|---|---|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Antonina Demski</i>  |                                  |   | 2. DATE OF DEATH<br><i>June 27 1950</i>   |   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>607 S. Grundy St</i>  |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY _____ |   |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>00</i>   |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 26-09</i>                            |   |  |
| C. Length of stay in Baltimore<br><i>36 years</i>  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><i>607 S. Grundy Street</i>  |   |  |
| 5. SEX<br><i>Female</i>  | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>married</i> | 8. DATE OF BIRTH<br><i>Dec 20 1885</i>  | 9. AGE (In years last birthday)<br><i>64</i>                          | If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.              |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>  |                                  |   | 11. BIRTHPLACE (State or foreign country)<br><i>Poland</i>  |   |  |
| 10B. KIND OF BUSINESS OR INDUSTRY  |                                  |   | 12. CITIZEN OF WHAT COUNTRY?  |   |  |
| 13. FATHER'S NAME<br><i>Felix Rutkowski</i>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><i>Ludwika ?</i>  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><i>Yes, no or unknown</i>   |                                  |   | 16. SOCIAL SECURITY NO.   |   |  |
| 18. <i>422.2</i>   |                                  |   | 17. INFORMANT<br><i>Joseph Demski 5108 + one</i>  |   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  |                                  |   | CAUSE OF DEATH<br><i>Myocardial Decomposition</i>   |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |                                  |   | (A) DUE TO<br><i>Myocarditis</i>  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                                  |   | (B) DUE TO  |   |  |
| 19A. DATE OF OPERATION <i>0</i>  |                                  |   | 19B. MAJOR FINDINGS OF OPERATION  |   |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |                                  |   | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |   |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                                  |   | 21D. HOW DID INJURY OCCUR?  |   |  |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> OR NOT WHILE AT WORK <input type="checkbox"/>  |                                  |   | 21F. HOW DID INJURY OCCUR?  |   |  |
| 22. I hereby certify that I attended the deceased from <i>March 14, 1948</i> to <i>June 27, 1950</i> , that I last saw the deceased alive on <i>June 27, 1950</i> , and that death occurred at <i>6 A.M.</i> , from the causes and on the date stated above. |                                  |   |   |   |  |
| 23A. SIGNATURE<br><i>Ea Hernandez Jr.</i>  |                                  |   | 23B. ADDRESS<br><i>3501 Fintar</i>  |   |  |
| 23C. DATE SIGNED<br><i>6-29-50</i>   |                                  |   |   |   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  |                                  | 24B. DATE<br><i>June 30/50</i>                                    | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Holy Rosary</i>  |   | 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore County</i> |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUN 29 1950</i>   |                                  | REGISTRAR'S SIGNATURE<br><i>Wilmington Williams, M.D.</i>         |   | FEDERAL DIRECTOR'S ADDRESS<br><i>John M. Weber, 401 S. Chesapeake</i> |  |

MEDICAL CERTIFICATION





525  
50 5733

50 5733

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Ernest Johnson

2. DATE  
OF  
DEATH

June 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

1722 Druid Hill Ave.

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Mar. 12 1895

9. AGE (In years  
last birthday)

55

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

Waiter

Public

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Adam Johnson

14. MOTHER'S MAIDEN NAME

Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

216-05-1326

17. INFORMANT

ADDRESS

Mrs. Mary Johnson 1722 Druid Hill

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) *Acute coronary Occlusion* 74 hr  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) *Myocardial Infarction* 6 mo  
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.(C) *Generalized Atherosclerosis* 8 mo

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

22. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Nov. 3*, 1949, to *June 28*, 1950, that I last saw the  
deceased alive on *June 28*, 1950, and that death occurred at *7:30 A. M.*, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

7-3-50

National Cemetery

Baltimore, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

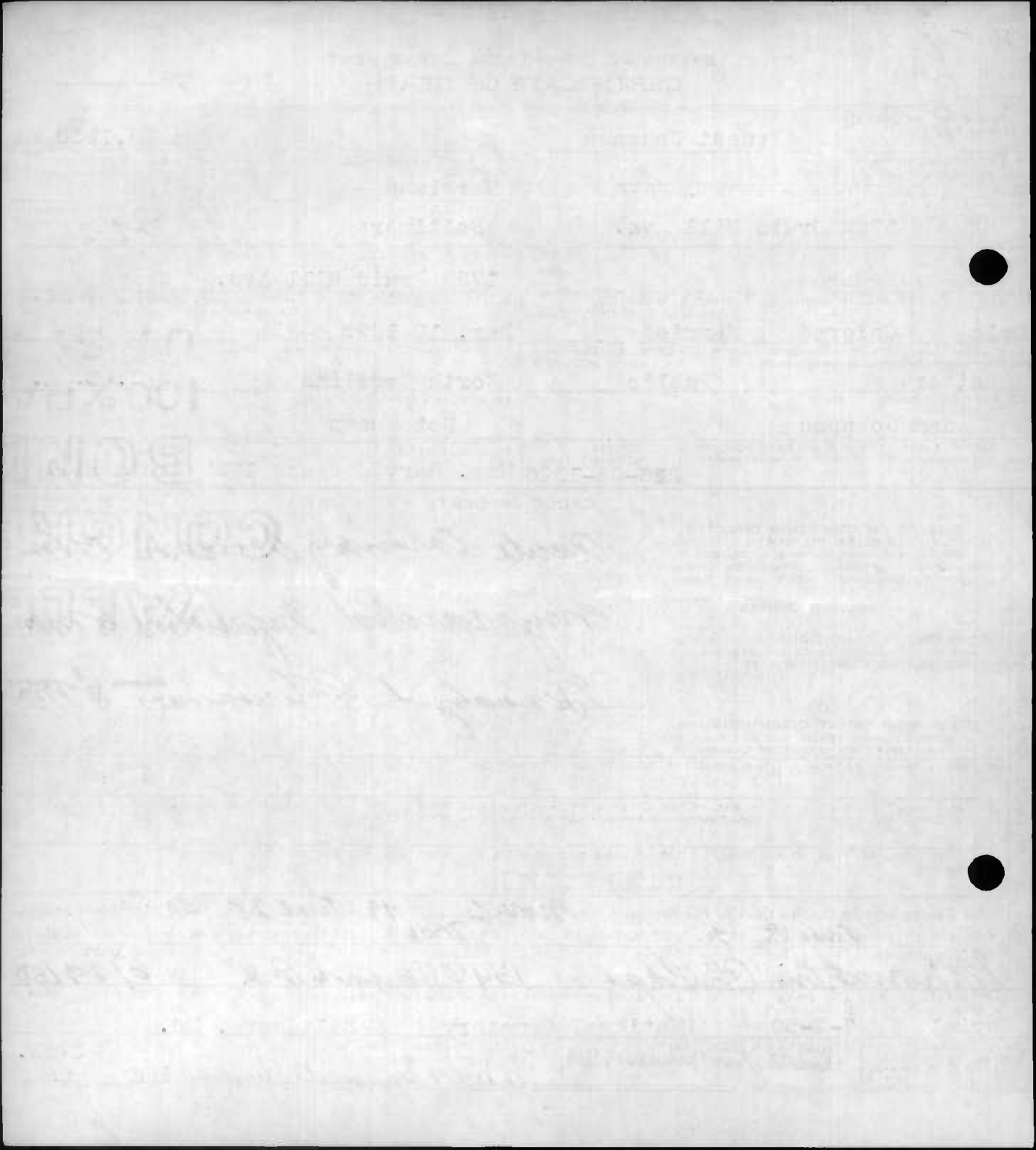
JUN 29 1950

Huntington Williams, Md.

Wm. T. Hensley, Piddle St.

78071

94a



152  
50 5734

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5734

Registered No.

|   |                                    |  |  |
|---|------------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>ANNIE ROBINSON</b>  |                                    | 2. DATE OF DEATH <b>JUNE 27, 1950</b>  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                    | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>8 N. Stockton Street</b> |                                    | C. CITY OR TOWN (If outside corporate limits write RURAL and give township)<br><b>BALTIMORE</b>                                |  |
| C. Length of stay in Baltimore  |                                    | D. STREET ADDRESS (If rural, give location)<br><b>8 N. Stockton St.</b>  |  |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>Colored</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widow</b>  | 8. DATE OF BIRTH<br><b>August 7, 1886</b>    |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Domestic</b>      |                                    | 10B. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (In years last birthday)<br><b>63</b> |
| 13. FATHER'S NAME<br><b>Robert Blackston</b>  |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)            |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A</b>   |  |
| 16. SOCIAL SECURITY NO.   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>MARGARET Goughen</b>  |  |
| 17. INFORMANT<br><b>Mrs. Ruth Brown</b>   |                                    | ADDRESS<br><b>1515 W. Fayette St.</b>  |  |

|   |                                |  |                                  |
|---|--------------------------------|--|----------------------------------|
| 18. <b>581.0</b>  | CAUSE OF DEATH                 |  | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) <b>CORONARY Occlusion</b>  |  | <b>Several Days</b>              |
| ANTECEDENT CAUSES   | (B) <b>Acute Cholecystitis</b> |  | <b>Several Months</b>            |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   | (C) <b>Hepatic Cirrhosis</b>   |  | <b>Unknown</b>                   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                                |  |                                  |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 19A. DATE OF OPERATION <b>6-30-50</b>   |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <b>4-27</b> , 19 <b>50</b> , to <b>6-27</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>6-24</b> , 19 <b>50</b> , and that death occurred at <b>1:35 A. m.</b> , from the causes and on the date stated above. |  |   |  |  |  |
| 23A. SIGNATURE<br><b>Richard H. Hunt</b>  |  | 23B. ADDRESS<br><b>1631 W. FRANKLIN ST.</b>   |  | 23C. DATE SIGNED   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>6-30-50</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn</b>                  |  |
| 24D. LOCATION (City, town, or county)<br><b>Baltimore</b>   |  | 24E. STATE<br><b>md</b>   |  | 24F. FUNERAL DIRECTOR<br><b>M. Francis G. Hensley</b>                    |  |
| 24G. ADDRESS<br><b>578 W. Biddle</b>  |  | 24H. DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 29 1950</b>   |  | 24I. REGISTRAR'S SIGNATURE<br><b>William J. Williams, M.D.</b>           |  |

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UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

PLANT INDUSTRY INVESTIGATION REPORT

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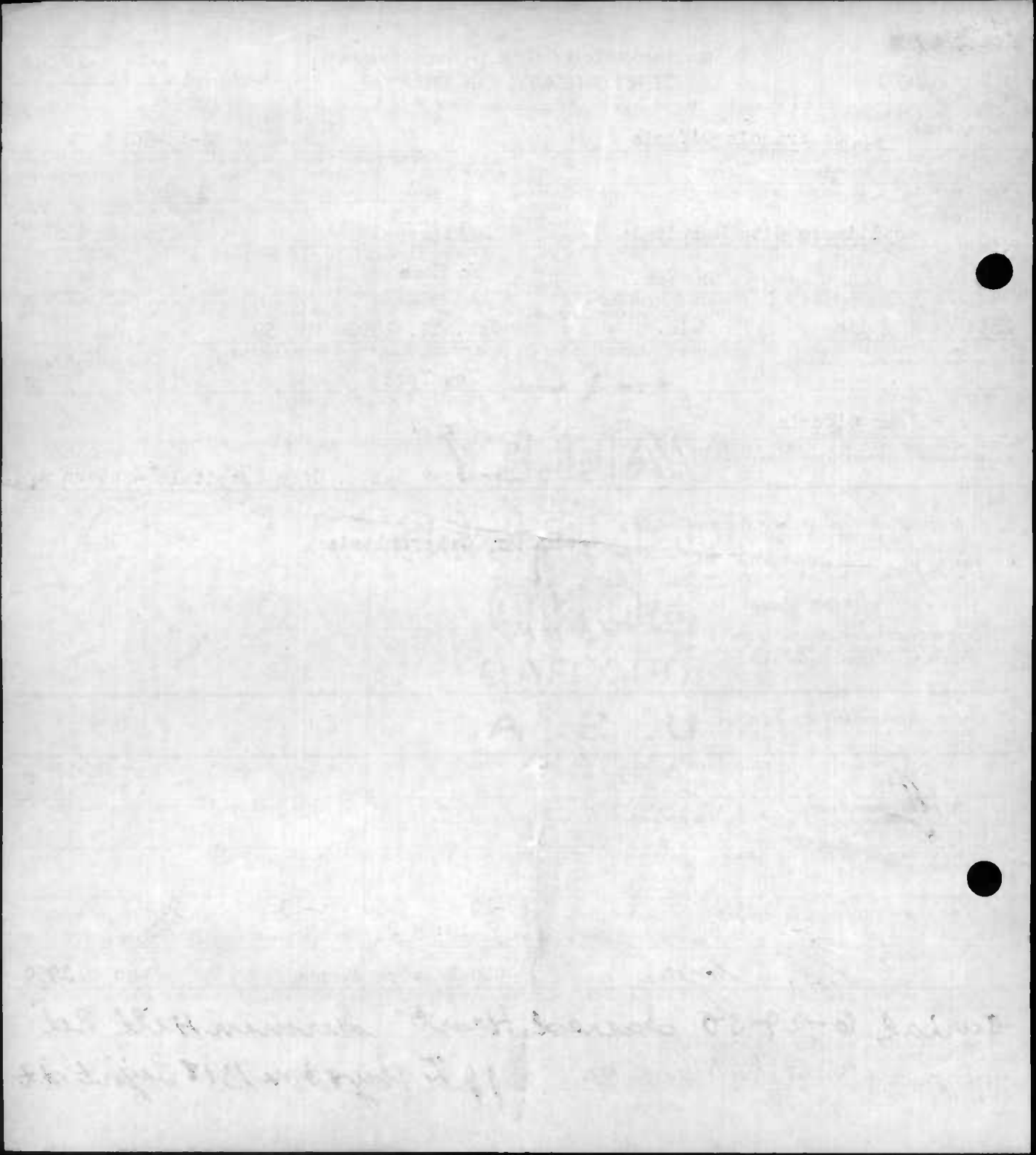
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5735  
Registered No. 50 5735

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>James Francis O'Toole</b>  |                                  | 2. DATE OF DEATH <b>6-13-50</b>  |  |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md</b><br>B. COUNTY |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Baltimore City Hospitals</b>   |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>                         |  |
| C. Length of stay in Baltimore <b>20 Yrs.</b>  |                                  | D. STREET ADDRESS (If rural, give location)<br><b>No Home</b>  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Wid.</b>   | 8. DATE OF BIRTH<br><b>Oct. 12, 1890</b>   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                                  | 10B. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (In years last birthday) <b>59</b><br>If Under 1 Year: Months: Days<br>If Under 24 Hours: Hours: Min. |
| 11. BIRTHPLACE (State or foreign country)<br><b>New York</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME<br><b>John O'Toole</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary ?</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT<br><b>Records* Balto. City Hospitals Eastern Ave.</b>  |                                  | ADDRESS <b>4940</b>  |  |
| 18. <b>002 X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Pulmonary Tuberculosis</b><br>(A) DUE TO<br><br>ANTECEDENT CAUSES<br>(B) DUE TO<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(C)<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                                  |  |  |
| 19A. DATE OF OPERATION <b>✓</b>  |                                  | 19B. MAJOR FINDINGS OF OPERATION   |  |
| 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                                |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                                  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) <b>6-13-50</b>   |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                |  |
| 21F. HOW DID INJURY OCCUR?   |                                  |  |  |
| 22. I hereby certify that I attended the deceased from <b>3-10</b> , 19 <b>50</b> , to <b>6-13</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>6-13</b> , 19 <b>50</b> , and that death occurred at <b>10:25 P.</b> , from the causes and on the date stated above.  |                                  |  |  |
| 23A. SIGNATURE<br><b>J. S. Ozen</b><br>M. D.   |                                  | 23B. ADDRESS<br><b>4940 Eastern Avenue</b>   |  |
| 23C. DATE SIGNED<br><b>June 29 1950</b>  |                                  |  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 24B. DATE<br><b>6-29-50</b>  |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart</b>  |                                  | 24D. LOCATION (City, town, or county) (State)<br><b>German Hill Rd</b>   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 29 1950</b>   |                                  | REGISTRAR'S SIGNATURE<br><b>Wilmington Williams, M.D.</b>  |  |
| 25. FUNERAL DIRECTOR<br><b>J. F. Z. &amp; Sons</b>   |                                  | ADDRESS<br><b>1318 Light St</b>  |  |

MEDICAL CERTIFICATION

13B





|   |                              |   |                                    |   |   |   |                                  |
|---|------------------------------|---|------------------------------------|---|---|---|----------------------------------|
| 636   |                              | 50 5736   |                                    | BALTIMORE CITY HEALTH DEPARTMENT  |   | 50 5736   |                                  |
| BIRTH NO.   |                              | CERTIFICATE OF DEATH  |                                    | Registered No.  |   |   |                                  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>ERIC FREDERICK</b>  |                              |   |                                    | 2. DATE OF DEATH<br><b>6/27/50</b>  |   |   |                                  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                              |   |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY |   |   |                                  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>MERCY HOSPITAL</b>  |                              |   |                                    | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTIMORE 22-01</b>                      |   |   |                                  |
| C. Length of stay in Baltimore <b>8</b> Yrs. <del>Mo.</del> Days  |                              |   |                                    | D. STREET ADDRESS (If rural, give location)<br><b>120 WARREN AVE</b>  |   |   |                                  |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>S</b>   | 8. DATE OF BIRTH<br><b>3-21-42</b> |   | 9. AGE (In years last birthday)<br><b>8</b> |   | 10. Under 1 Year<br>Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>STUDENT</b>   |                              | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>McDonough</b>   |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE Md.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                   |                                  |
| 13. FATHER'S NAME<br><b>ERIC FREDERICK</b>  |                              |   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>KATHRYN SCOTT</b>  |   |   |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>No</b>  |                              | 16. SOCIAL SECURITY NO.   |                                    | 17. INFORMANT<br><b>Family - Same</b>   |   | ADDRESS   |                                  |
| 18. <b>010X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>(A) TUBERCULOUS MENINGITIS</b><br>DUE TO              |                              |   |                                    | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 mo.</b>  |   |   |                                  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>(B)</b><br>DUE TO  |                              |   |                                    |   |   |   |                                  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>(C)</b>   |                              |   |                                    |   |   |   |                                  |
| 19A. DATE OF OPERATION<br><b>6/27/50</b>  |                              | 19B. MAJOR FINDINGS OF OPERATION  |                                    | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |   |                                  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |   |                                  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>INJURY   |                              | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |                                    | 21F. HOW DID INJURY OCCUR?  |   |   |                                  |
| 22. I hereby certify that I attended the deceased from <b>6/15</b> , 19 <b>50</b> , to <b>6/27</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>6/27</b> , 19 <b>50</b> , and that death occurred at <b>10 P</b> m., from the causes and on the date stated above. |                              |   |                                    |   |   |   |                                  |
| 23A. SIGNATURE<br><b>Gene W. Nevin</b> M. O.  |                              |   |                                    | 23B. ADDRESS<br><b>Mercy Hospital</b>   |   | 23C. DATE SIGNED<br><b>6/28/50</b>                            |                                  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>B.</b>  |                              | 24B. DATE<br><b>6-30-50</b>   |                                    | 24C. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL</b>   |   | 24D. LOCATION (City, town, or county) (State)<br><b>BALTO</b> |                                  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>29 1950</b>  |                              | REGISTRAR'S SIGNATURE<br><b>William L. Williams, M.D.</b>   |                                    | 25. FUNERAL DIRECTOR<br><b>James L. DeConey</b>   |   | ADDRESS<br><b>130 E FORT AVE.</b>                             |                                  |

MEDICAL CERTIFICATION

14

STATE OF TEXAS  
COUNTY OF DALLAS



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

50 5737

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Shirley D. Ennis*

2. DATE  
OF  
DEATH

*6/27/50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

*University Hospital*

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

*Maryland*

*Howard*

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

*Daniels*

*6200*

D. STREET ADDRESS (If rural, give location)

C. Length of stay in Baltimore

*13*

Yrs.  
Mos.  
Days

5. SEX

*m*

6. COLOR OR RACE

*w*

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

*Married*

8. DATE OF BIRTH

*3-8-1905*

9. AGE (in years  
last birthday)

*45*

10 Under 1 Year  
Months: Days

11 Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

*Mill Hand*

10B. KIND OF BUSINESS OR  
INDUSTRY

*Cotton Duck Mill*

11. BIRTHPLACE (State or foreign country)

*Virginia*

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

*Noah A. Ennis*

14. MOTHER'S MAIDEN NAME

*Mahaley Reiley*

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

*No*

16. SOCIAL  
SECURITY NO.  
*216-07-4243*

17. INFORMANT

ADDRESS

*Edna Ennis, Daniels, Md*

18. *420.1*

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

*Myocardial failure*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

*Heart coronary insufficiency*

DUE TO

*Myocardial infarction*

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

22. I hereby certify that I attended the deceased from *6/14*, 1950, to *6/27*, 1950, that I last saw the deceased alive on *6/27*, 1950, and that death occurred at *4:50 P. M.*, from the causes and on the date stated above.

23A. SIGNATURE

*Veel R. McLeant Jr.*

23B. ADDRESS

*University Hosp.*

23C. DATE SIGNED

*6/27/50*

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

*Burial*

24B. DATE

*7-1-50*

24C. NAME OF CEMETERY OR CREMATORY

*Good Shepherd*

24D. LOCATION (City, town, or county)

*Ellicott City, Md.*

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

*JUN 29 1950*

REGISTRAR'S SIGNATURE

*Wilmington Williams, Md*

25. FUNERAL DIRECTOR

ADDRESS

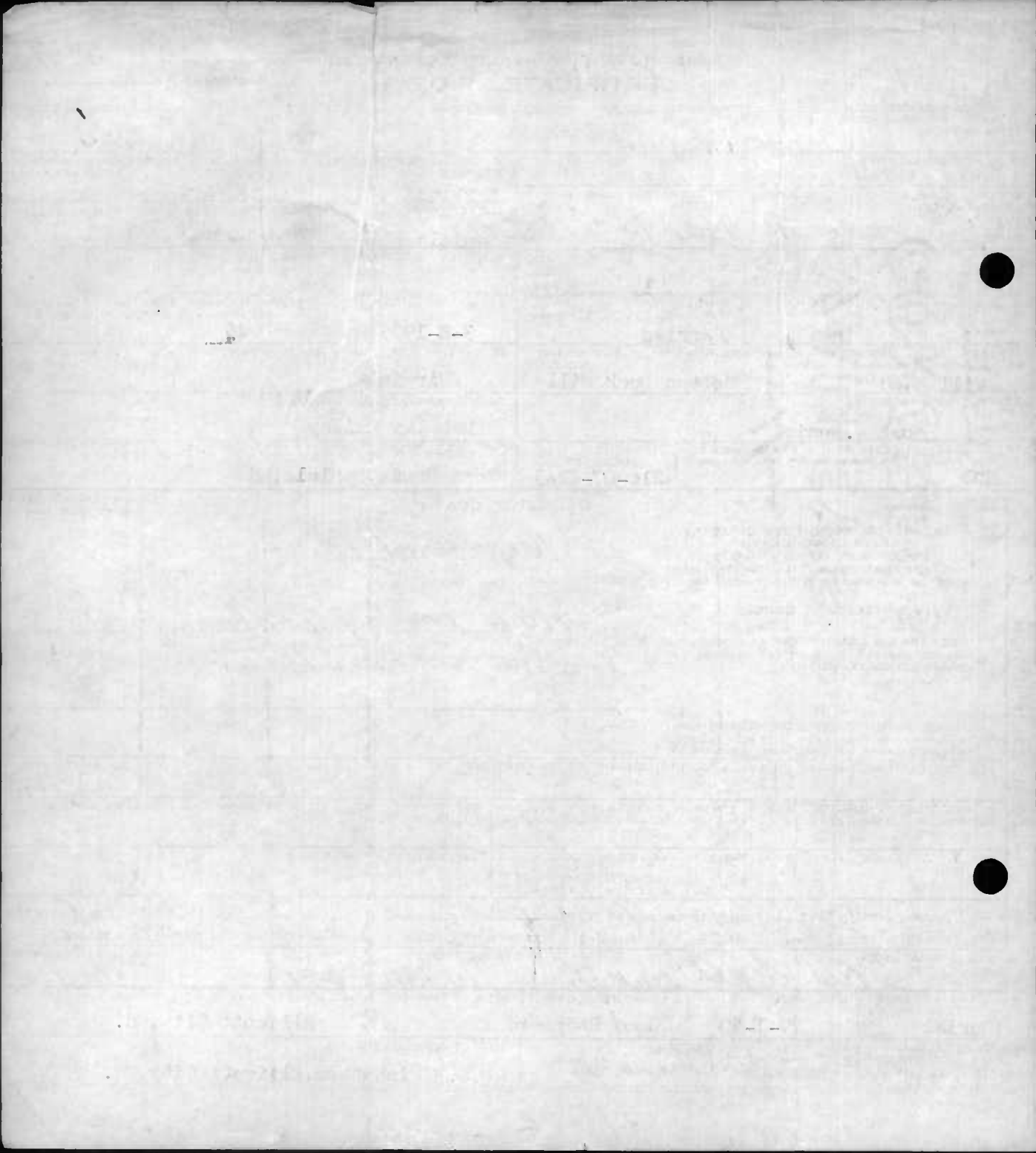
*F. C. Higinbotham, Ellicott City, Md.*

VS 150

*496 X 8*

*94a*

MEDICAL CERTIFICATION



20 50 5738

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5738  
Registered No.

BIRTH NO.

|  |                              |  |                                      |
|--|------------------------------|--|--------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Clarence L. Price</b>  |                              | 2. DATE OF DEATH<br><b>6-29-50</b>   |                                      |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |                                      |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Maryland General Hosp.</b>                                       |                              | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 27-08B</b>                        |                                      |
| D. Length of stay in Baltimore<br><b>60</b> (Yrs. Mos. Days)   |                              | E. STREET ADDRESS (If rural, give location)<br><b>513 Tunbridge Rd #12</b>   |                                      |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>M</b>  | 8. DATE OF BIRTH<br><b>6-10-1890</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Salesman</b> |                              | 9. AGE (In years last birthday)<br><b>60</b>   |                                      |
| 10B. KIND OF BUSINESS OR INDUSTRY<br><b>PRINTING (W)</b>   |                              | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                      |
| 13. FATHER'S NAME<br><b>Abraham Price</b>  |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)       |                              | 14. MOTHER'S MAIDEN NAME<br><b>Siranda Coler</b>   |                                      |
| 16. SOCIAL SECURITY NO.<br><b>217-09-8554</b>  |                              | 17. INFORMANT ADDRESS<br><b>Bessie L Price (wife) as above</b>   |                                      |

|  |  |  |
|--|--|--|
| 18. <b>442 X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cerebrovascular accident</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>12 days</b> |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Hypertensive cardiovascular disease</b>   |  | <b>several years</b>                               |
| (B) <b>generalized arteriosclerosis</b>  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |  |

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 19A. DATE OF OPERATION <b>0</b>  |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>6-19, 1950</b> to <b>6-29, 1950</b> , that I last saw the deceased alive on <b>6/28, 1950</b> and that death occurred at <b>442A</b> , from the causes and on the date stated above. |  |  |  |   |  |
| 23A. SIGNATURE<br><b>Marguerite Louisa (Cady)</b>  |  | 23B. ADDRESS<br><b>Maryland General Hosp.</b>  |  | 23C. DATE SIGNED<br><b>6/29/50</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 24B. DATE<br><b>7-1-1950</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>WESTMINISTER CEM.</b>                      |  |
| 24D. LOCATION (City, town, or county)<br><b>WESTMINISTER MD.</b>   |  | 24E. FUNERAL DIRECTOR<br><b>H.W. JENKINS &amp; Sons Co.</b>  |  | 24F. ADDRESS<br><b>4905 York Rd</b>   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 29 1950</b>   |  | REGISTRAR'S SIGNATURE<br><b>William H. Williams, M.D.</b>  |  | 25. FUNERAL DIRECTOR ADDRESS  |  |

27814

93D

MEDICAL CERTIFICATION



Chambers L. Price 12-29-30

Wm. L. and

M. and J. Chambers

12-29-30

210 Thompson St. N.Y.

W-10-1000

M

B

M

12-29

Wm. L. and

Chambers

Chambers L. Price

Chambers L. Price (note)

Chambers L. Price (note)

12-29

Chambers L. Price (note)

Chambers L. Price (note)

12-29-30

1941

Chambers L. Price (note)

Chambers L. Price (note)

Chambers L. Price (note)

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5739  
Registered No. \_\_\_\_\_

BIRTH NO. 50 5739

|  |                                  |   |   |  |   |
|--|----------------------------------|---|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Martha Ellen Bujac</b>   |                                  |   | 2. DATE OF DEATH <b>June 28, 1950</b>   |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b><br>B. COUNTY _____ |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>1643 N. Bentalou St.,</b> |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>                                |  |   |
| C. Length of stay in Baltimore<br>Yrs. _____<br>Mos. _____<br>Days _____   |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>1643 N. Bentalou St.,</b>   |  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b> | B. DATE OF BIRTH<br><b>June 16, 1892</b>  |  | 9. AGE (In years last birthday)<br><b>58</b>            |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Stenographer</b>                   |                                  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Leber Bros.</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b> |
| 13. FATHER'S NAME<br><b>Thomas E. Morgan</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Sarah Tarleton</b>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)  |                                  | 16. SOCIAL SECURITY NO.<br><b>216-01-2547</b>                     | 17. INFORMANT ADDRESS<br><b>Miss Sadie N. Morgan 1643 N. Bentalou St.</b>   |  |   |

|  |  |   |
|--|--|---|
| 18. <b>420.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>coronary thrombosis</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b> |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>mixed cerebral apoplexy</b>   |  |   |
| (C) <b>arterio-sclerosis</b>   |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>acute enteritis</b>  |  | <b>2 days</b>                                     |

|   |   |  |  |  |
|---|---|--|--|--|
| 19A. DATE OF OPERATION <b>0</b>   |   | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDER-<br>LYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>INJURY   | 21E. INJURY OCCURRED<br>WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK | 21F. HOW DID INJURY OCCUR?   |  |  |

22. I hereby certify that I attended the deceased from **June 26, 1950**, to **June 28, 1950**, that I last saw the deceased alive on **June 27, 1950**, and that death occurred at **2:00 A.m.**, from the causes and on the date stated above.

|  |  |                                    |
|--|--|------------------------------------|
| 23A. SIGNATURE<br><b>Marion E. Shanley</b> | 23B. ADDRESS<br><b>3800 W. North Ave</b> | 23C. DATE SIGNED<br><b>6/29/50</b> |
|--|--|------------------------------------|

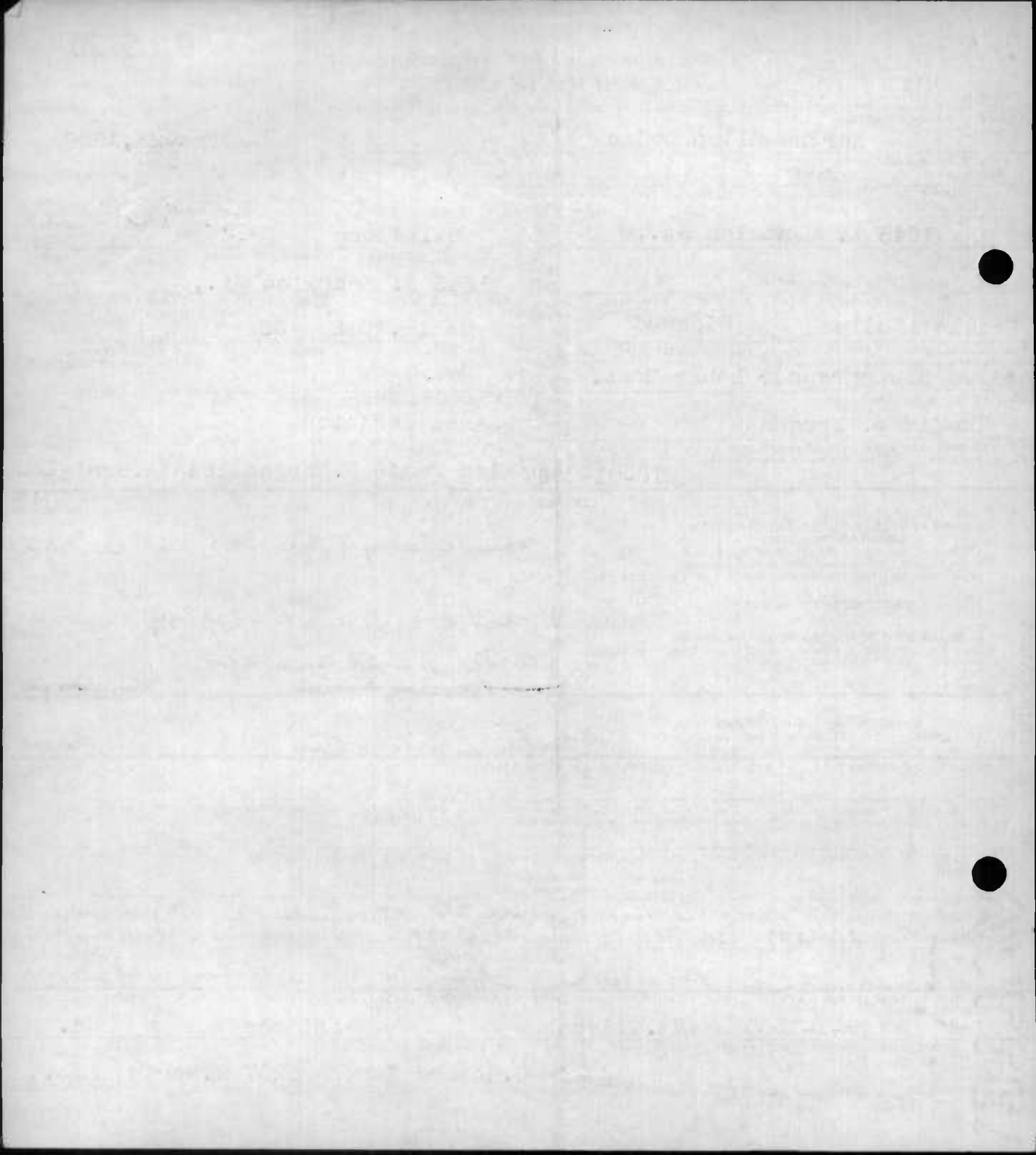
|  |                              |   |   |
|--|------------------------------|---|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24B. DATE<br><b>7-1-1950</b> | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet</b> | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Md.</b> |
|--|------------------------------|---|---|

|                                  |   |   |                                       |
|----------------------------------|---|---|---------------------------------------|
| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b> | 25. FUNERAL DIRECTOR<br><b>G. Howard Strong</b> | ADDRESS<br><b>3207 W. North Ave.,</b> |
|----------------------------------|---|---|---------------------------------------|

JUN 29 1950

23617

94a



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5740

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)Alias  
JAMES HARNEY KREMER - Knowles2. DATE  
OF  
DEATH

JUNE 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE  
MARYLANDB. COUNTY  
BALT.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

12-05

D. STREET ADDRESS (If rural, give location)

1804 ST. PAUL STREET

C. Length of stay in Baltimore

YRS

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

S

B. DATE OF BIRTH

OCT 20, 1887

9. AGE (In years  
last birthday)

72

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

GAS COMPANY

10B. KIND OF BUSINESS OR  
INDUSTRY

HEATING ENG.

11. BIRTHPLACE (State or foreign country)

STEPHENSON CO. ILL.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

NEWTON KNOWLES

14. MOTHER'S MAIDEN NAME

CELINDA HARNEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

UNK.

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

MISS M. ELEANOR FARRELL 303 E. NORTH AVE.

18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) ARTERIOSCLEROTIC HEART DISEASE

YRS.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) GENERALIZED ARTERIOSCLEROSIS

YRS.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) CEREBRO - VASCULAR ACCIDENT

1 WEEK

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐22. I hereby certify that I attended the deceased from JUNE 1, 1950, to JUNE 27, 1950, that I last saw the  
deceased alive on JUNE 27, 1950, and that death occurred at 5:10 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Donald L. Somerville M.D.

23B. ADDRESS

Union Mem. Hosp

23C. DATE SIGNED

6/28/50

24. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

6/30/50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore National

24D. LOCATION (City, town, or county)

Baltimore, Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

L. J. Ruck, 5305 Harford Rd

JUN 29 1950

V22 59

937

EASTMAN'S  
CENTRAL PLATE OF DEATH

1911

1912

1913

1914

1915

1916

1917

1918

1919

1920

1921

1922

1923

1924

1925

1926

1927

1928

525  
50 5741BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5741  
Registered No.

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>KATHERINE ANNA HANSON</b>  |                                  | 2. DATE OF DEATH<br><b>June 28, 1950</b>   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE<br><b>Md.</b><br>B. COUNTY |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTE<br><b>2513 Edmondson Ave.</b>   |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)<br><b>Baltimore</b> <b>20-02</b>               |   |
| C. Length of stay in Baltimore<br>Yrs.<br>Mos.<br>Days  |                                  | D. STREET ADDRESS (If rural, give location)<br><b>2513 Edmondson Ave.</b>  |   |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>widowed</b>  | 8. DATE OF BIRTH<br><b>July 5, 1865</b> |
| 9. AGE (In years last birthday)<br><b>84</b>  |                                  | 10. Under 1 Year Months Days<br>11. Under 24 Hours Hours Min.  |   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY  |   |
| 13. FATHER'S NAME<br><b>Haas</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Katherine Pabst</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT<br><b>Miss Edna G. Hanson - 2513 Edmondson Ave.</b>   |                                  | ADDRESS  |   |
| 18. <b>420.0</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Antenatal Heart Disease</b><br>DUE TO<br><b>Secondary Arteriosclerosis</b><br>DUE TO<br><b>?</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>5 yrs.</b><br><b>?</b> |                                  | CAUSE OF DEATH<br><b>Antenatal Heart Disease</b><br><b>Secondary Arteriosclerosis</b><br><b>?</b>                            |   |
| 19A. DATE OF OPERATION<br><b>0</b>  |                                  | 19B. MAJOR FINDINGS OF OPERATION   |   |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                  |  |   |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                                    |   |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                                  |  |   |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                    |   |
| 21F. HOW DID INJURY OCCUR?  |                                  |  |   |
| 22. I hereby certify that I attended the deceased from <b>Dec 26, 1946</b> to <b>June 28, 1950</b> that I last saw the deceased alive on <b>June 27, 1950</b> and that death occurred at <b>10 A. m.</b> , from the causes and on the date stated above.  |                                  |  |   |
| 23A. SIGNATURE<br><b>Albert Phochol</b>   |                                  | 23B. ADDRESS<br><b>2302 Edmondson Ave.</b>   |   |
| 23C. DATE SIGNED<br><b>5/28/50</b>  |                                  |  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 24B. DATE<br><b>7/1/50</b>   |   |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Carmel Cem.</b>  |                                  | 24D. LOCATION (City, town, or county) (State)<br><b>Balto., Md.</b>  |   |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 29 1950</b>  |                                  | 25. FUNERAL DIRECTOR<br><b>Wm. J. Sicker</b>   |   |
| VS 150  |                                  | ADDRESS<br><b>Long-Guth</b><br><b>937 RMD.</b>   |   |



CONFIDENTIAL

ATTENTION

CONFIDENTIAL

CONFIDENTIAL

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5742  
Registered No. \_\_\_\_\_

|   |                                  |   |  |  |  |
|---|----------------------------------|---|--|--|--|
| BIRTH NO. _____   |                                  | 1. NAME OF DECEASED<br>(Type or Print) <b>MARY IDA HORSEMAN</b>   |  | 2. DATE OF DEATH<br><b>June 27, 1950</b>                                 |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <b>Md.</b><br>B. COUNTY _____ |  |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>129 W. Ostend St.</b>   |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)<br><b>Baltimore 23-01</b>                         |  |  |  |
| C. Length of stay in Baltimore<br>Yrs. _____<br>Mos. _____<br>Days _____  |                                  | D. STREET ADDRESS (If rural, give location)<br><b>129 W. Ostend St.</b>   |  |  |  |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>widowed</b>   |  | 8. DATE OF BIRTH<br><b>Oct. 8, 1862</b>                                  | 9. AGE (In years last birthday)<br><b>87</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>at home</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>             |  |
| 13. FATHER'S NAME<br><b>Benjamin Bromwell</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br>(If yes, give war or dates of service)     |                                  | 16. SOCIAL SECURITY NO. _____   |  | 17. INFORMANT ADDRESS<br><b>Mrs. Ethel M. Woollen 405 W. Forest View</b> |  |

|  |  |   |
|--|--|---|
| 18. <b>420.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | CAUSE OF DEATH<br><br>(A) <b>Sclerotic coronary disease</b><br>DUE TO<br><br>(B) <b>General arterio sclerosis</b><br>DUE TO<br><br>(C) _____ | INTERVAL BETWEEN ONSET AND DEATH<br><br><b>about 3 mos.</b><br><br><b>?</b> |
|  |  |   |
|  |  |   |

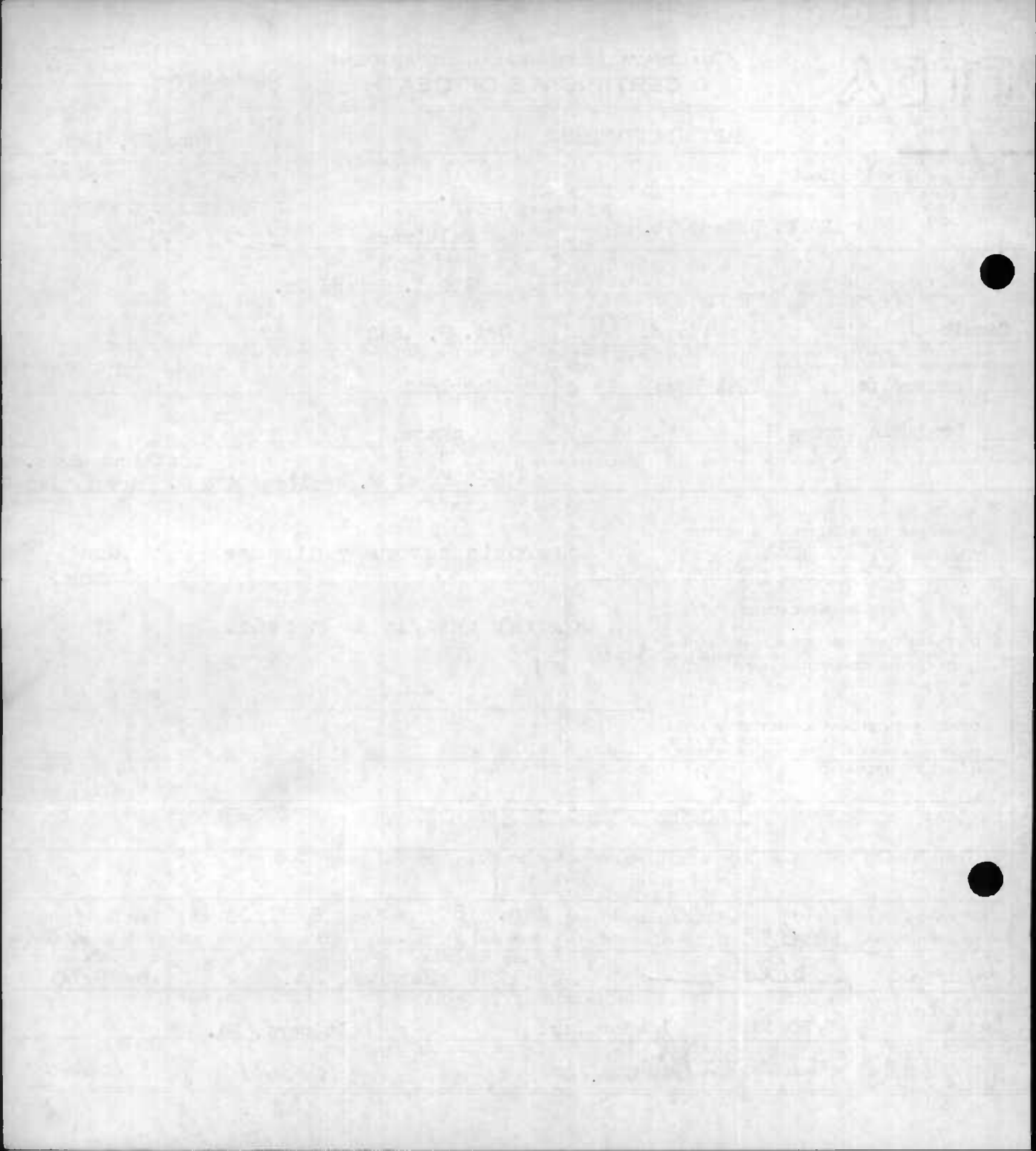
|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 19A. DATE OF OPERATION<br><b>6/28/50</b>               |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)             |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br><b>INJURY</b> |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |

22. I hereby certify that I attended the deceased from **Mar. 18, 1950** to **6/27/50**, that I last saw the deceased alive on **6/26/50**, and that death occurred at **P. m.**, from the causes and on the date stated above.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 23A. SIGNATURE<br><b>Harry Deibel</b>                      |  | 23B. ADDRESS<br>M. D. <b>1226 Hanover St.</b> |  | 23C. DATE SIGNED<br><b>6/28/50</b>                                     |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> |  | 24B. DATE<br><b>6/30/50</b>                   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>               |  |
|  |  |   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b> |  |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 29 1950</b> |  | REGISTRAR'S SIGNATURE<br><b>Thurston Williams, M.D.</b> |  | 25. FUNERAL DIRECTOR<br><b>Wm. F. Dickner &amp; Son</b> |  |
|  |  |   |  | ADDRESS<br><b>Balto</b>                                 |  |

94a md.



640

50 5743

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5743  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ERNEST G. SHIRLEY

2. DATE  
OF  
DEATH

6/29/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

29 Univ. of Maryland Hospital

Yes.  
Mos.  
Days

C. Length of stay in Baltimore

9

5. SEX

M.

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

3/13/1885

9. AGE (In years,  
last birthday)

65

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Train master

10B. KIND OF BUSINESS OR  
INDUSTRY

Railroad

13. FATHER'S NAME

L. J. Shirley

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF  
WHAT COUNTRY?

USA.

14. MOTHER'S MAIDEN NAME

Anne C. Hegelman

17. INFORMANT

Ethel T. SCHLEY

ADDRESS

18. 332X I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Thrombosis Cerebral artery, left.

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Hemiplegia, right

DUE TO

(C) Generalized Arteriosclerosis

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

6/26/50

19B. MAJOR FINDINGS OF OPERATION

Pneumothorax - negative

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/20, 1950, to 6/29, 1950, that I last saw the  
deceased alive on 6/29, 1950, and that death occurred at 2:35 AM., from the causes and on the date stated above.

23A. SIGNATURE

Mark S. West, Jr.

M. D.

23B. ADDRESS

267 Md. Hosp.

23C. DATE SIGNED

6/29/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

July, 1950

24C. NAME OF CEMETERY OR CREMATORY

Edgwood Cem.

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, Md.

25. FUNERAL DIRECTOR

ADDRESS

267 Md. Hosp.

VS 150

JUN 29 1950

156 47

Baltimore, Md. 82B

MEDICAL CERTIFICATION

CONFIDENTIAL

CONFIDENTIAL

420

50 5744

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5744

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

James R. Willis

2. DATE  
OF  
DEATH

June 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution; residence  
before admission)

A. STATE

Md

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore 25-04

D. STREET ADDRESS (If rural, give location)

4134

6th St

C. Length of stay in Baltimore

16

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

3-30-34

9. AGE (In years  
last birthday)

16

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR  
INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

George A. Willis

14. MOTHER'S MAIDEN NAME

Marie Richardson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

George A. Willis

18. 401.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Rheumatic fever, active

INTERVAL BETWEEN  
ONSET AND DEATH

10 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Rheumatic heart disease

11

(C)

mitral stenosis, mitral insufficiency,  
aortic insufficiency, + myocarditisOTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

INJURY

m.

WHILE AT ☐NOT WHILE ☐22. I hereby certify that I attended the deceased from 6/23, 1950, to 6/28, 1950, that I last saw the  
deceased alive on 6/28, 1950, and that death occurred at 12:00 AM, from the causes and on the date stated above.

23A. SIGNATURE

Edy H. H. Schenck

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

6/28/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

7/1/50

24C. NAME OF CEMETERY OR CREMATORY

Holy Cross

24D. LOCATION (City, town, or county)

Annapolis, Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

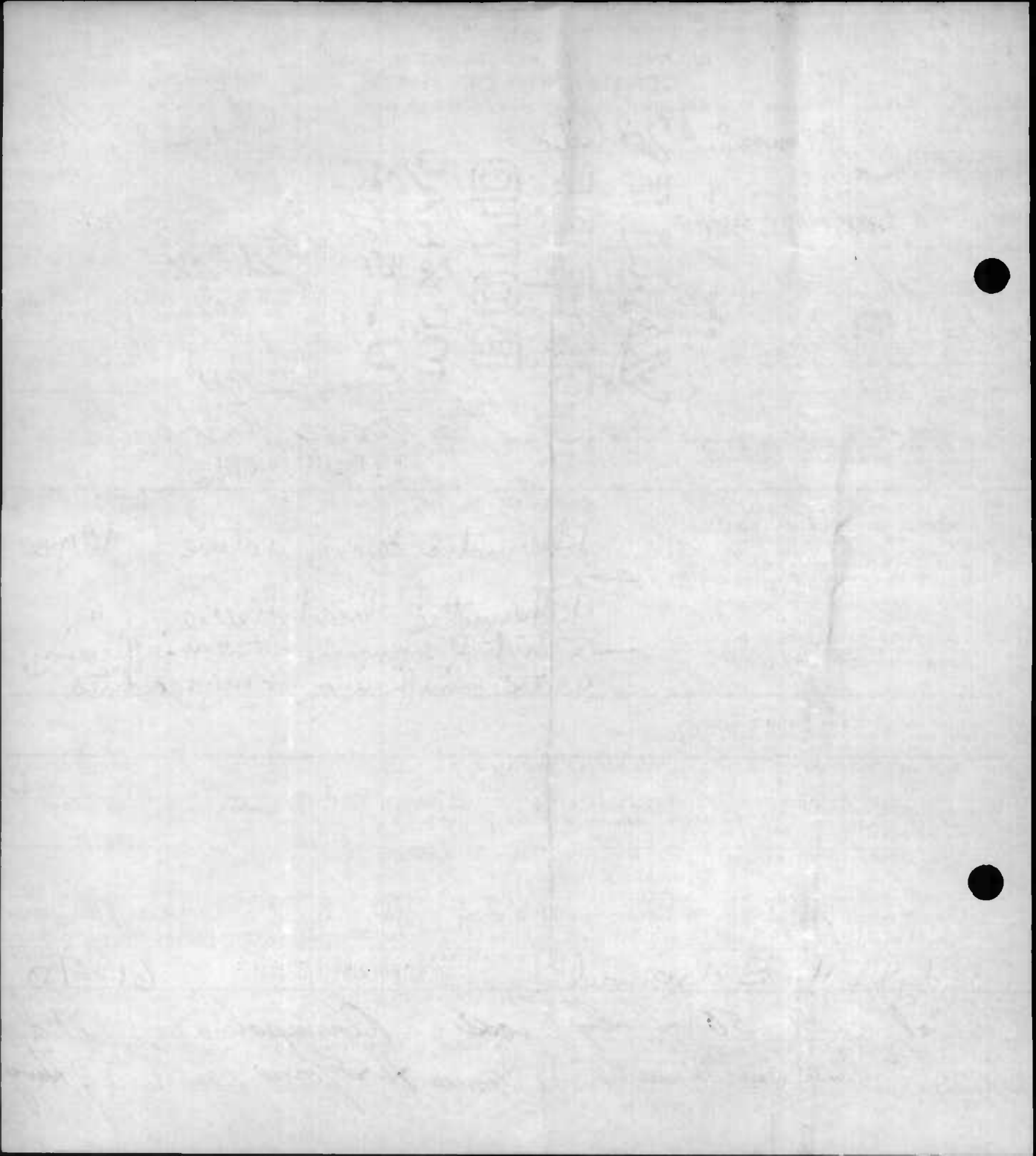
ADDRESS

James H. Lyons, 4001 Ritchie Hwy

VS 150

58 B

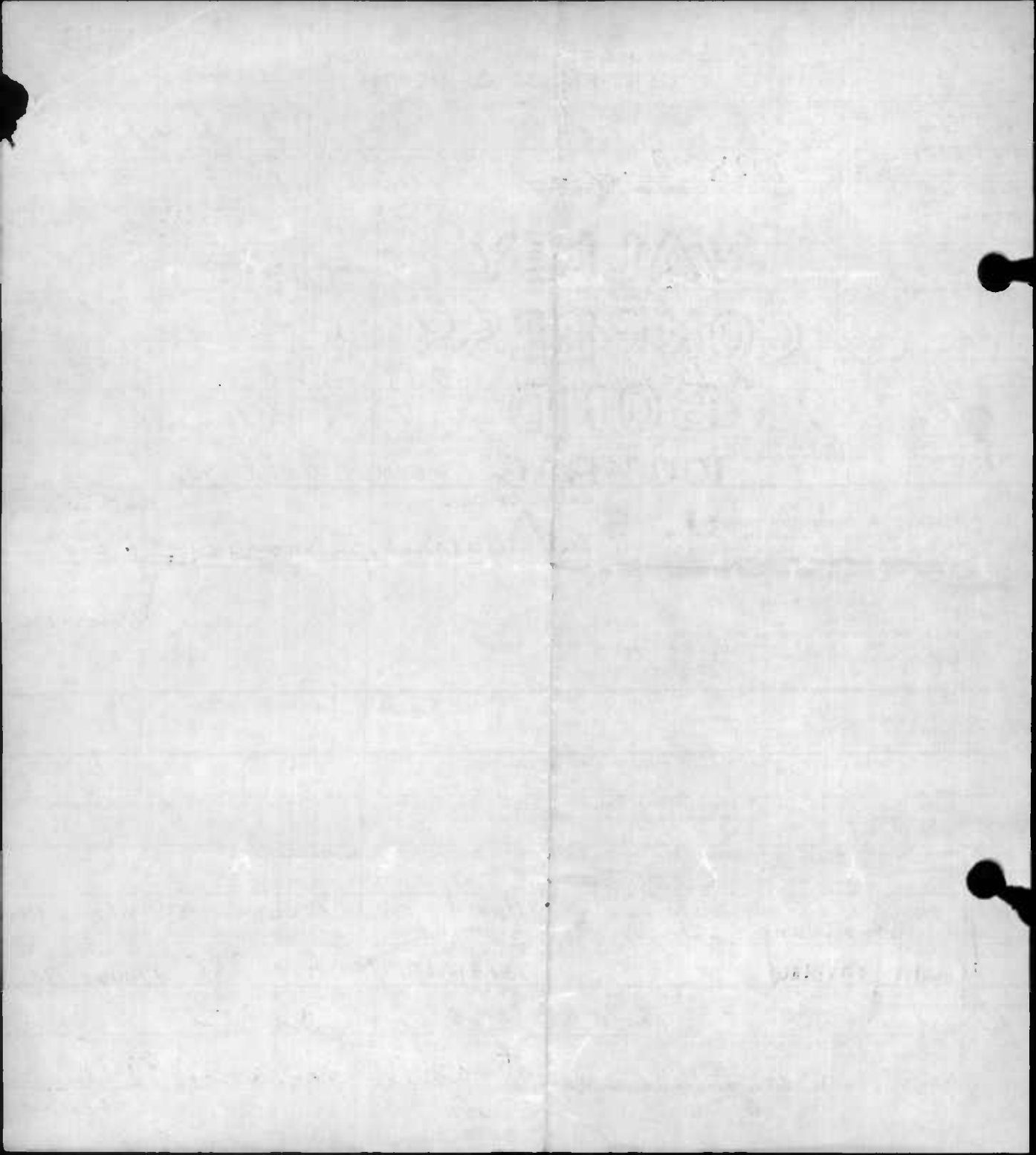




| BALTIMORE CITY HEALTH DEPARTMENT   |  |  |  | Registered No.  |  |  |  |
|--|--|--|--|---|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |
| BIRTH NO.  |  |  |  | 50 5745   |  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Michael John Kuratnick</i>   |  |  |  | 2. DATE OF DEATH <i>June 29, 1950</i>   |  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |  |  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)<br>A. STATE <i>Delaware</i> B. COUNTY <i>V-07</i>   |  |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>JOHNS HOPKINS HOSPITAL</i>   |  |  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Laurel</i>   |  |  |  |
| C. Length of stay in Baltimore   |  |  |  | D. STREET ADDRESS (If rural, give location)<br><i>907 1/2 West St.</i>  |  |  |  |
| 5. SEX <i>male</i> 6. COLOR OR RACE <i>white</i> 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)   |  |  |  | 8. DATE OF BIRTH <i>8-26-48</i> 9. AGE (In years last birthday) <i>22</i> If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min.  |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |  |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 11. BIRTHPLACE (State or foreign country)<br><i>Buenos Aires, Argentina</i>  |  |  |  | 12. CITIZEN OF WHAT COUNTRY?  |  |  |  |
| 13. FATHER'S NAME<br><i>Michael Kuratnick</i>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><i>Helen Kluznik</i>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |  |  |  | 16. SOCIAL SECURITY NO.   |  |  |  |
| 17. INFORMANT<br><i>JOHNS HOPKINS HOSPITAL</i>   |  |  |  | ADDRESS   |  |  |  |
| 18. 754.6 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  |  |  | CAUSE OF DEATH<br>(A) <i>Cardiac Failure following</i><br>DUE TO <i>Operation for Congenital</i><br>(B) <i>Heart Disease</i><br>DUE TO<br>(C)<br>INTERVAL BETWEEN ONSET AND DEATH |  |  |  |
| 19A. DATE OF OPERATION<br><i>6/29/50</i>   |  |  |  | 19B. MAJOR FINDINGS OF OPERATION<br><i>Pulmonic Stenosis</i>  |  |  |  |
| 20. AUTOBPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |  |  |  |
| 21A. ACCIDENT WAS UNDER- Lying <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |  |  |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  |  |   |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) MIN INJURY   |  |  |  | 21E. INJURY OCCURRED<br>WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  |
| 21F. HOW DID INJURY OCCUR?   |  |  |  |   |  |  |  |
| 22. I hereby certify that I attended the deceased from <i>6/26</i> , 1950, to <i>6/29</i> , 1950, that I last saw the deceased alive on <i>6/29</i> , 1950, and that death occurred at <i>12</i> m., from the causes and on the date stated above.   |  |  |  |   |  |  |  |
| 23A. SIGNATURE<br><i>J. P. Johns</i>   |  |  |  | 23B. ADDRESS<br><i>JOHNS HOPKINS HOSPITAL</i>   |  |  |  |
| 23C. DATE SIGNED   |  |  |  |   |  |  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Shipment</i>   |  |  |  | 24B. DATE<br><i>June 30, 1950</i>   |  |  |  |
| 24C. NAME OF CEMETERY OR CREMATORY   |  |  |  | 24D. LOCATION (City, town, or county) (State)<br><i>Scranton, Penna.</i>  |  |  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUN 29 1950</i>   |  |  |  | REGISTRAR'S SIGNATURE<br><i>Wilmington Williams, M.D.</i>   |  |  |  |
| 25. FUNERAL DIRECTOR<br><i>Schimunek Funeral Home, Inc.</i>  |  |  |  | ADDRESS<br><i>2601-3-5 E. Madison Street</i><br><i>Charles E. Schimunek 157E</i>  |  |  |  |

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*





322  
532  
0 5747

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5747  
Registered No.

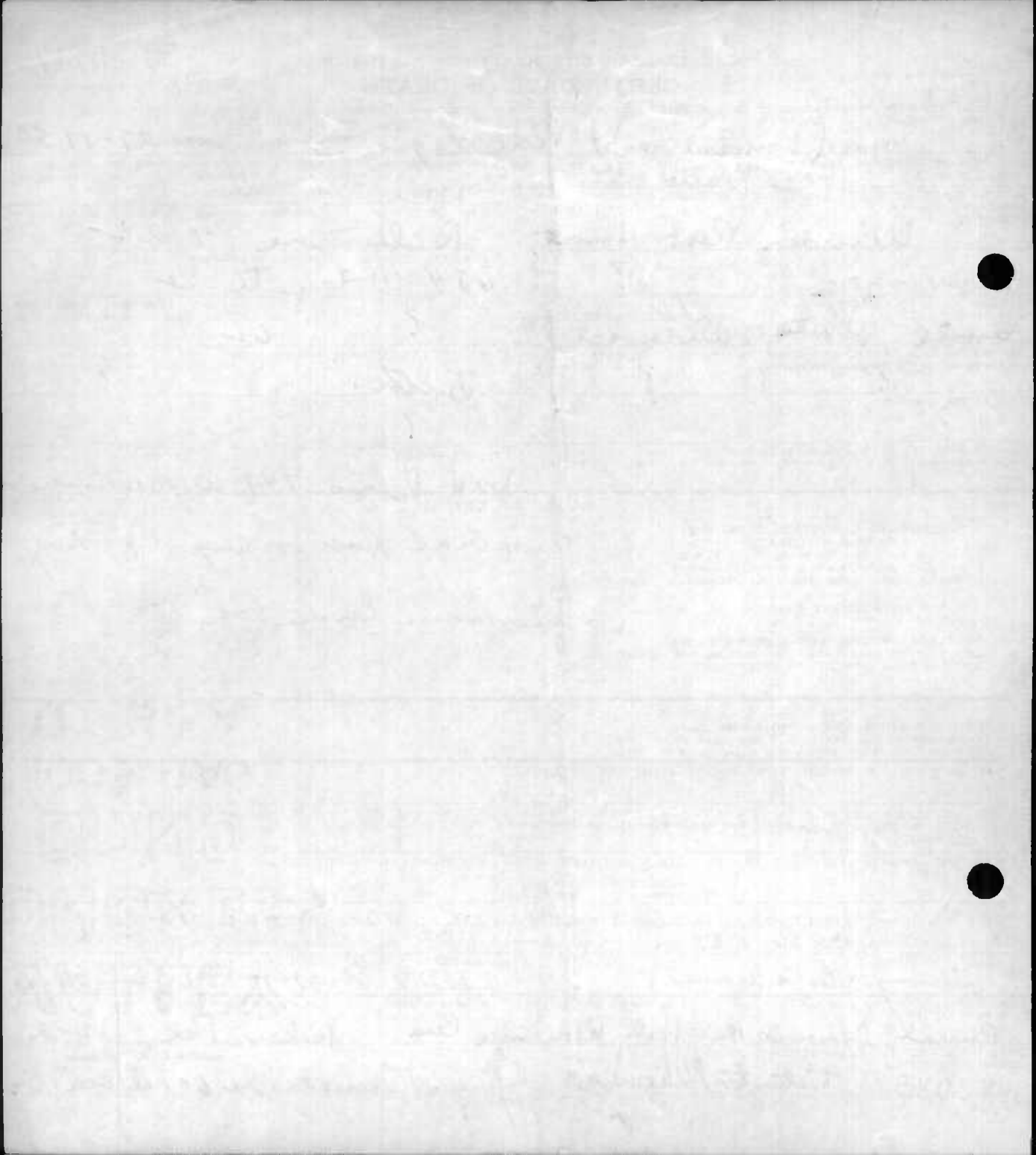
|   |                                  |   |  |  |  |
|---|----------------------------------|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Mare Jendaugiene Van degis</i>  |                                  |   | 2. DATE OF DEATH<br><i>June 27-1950</i>  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>Balto City</i>   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)<br>A. STATE <i>md</i> B. COUNTY          |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>Windsor Rest Home</i>   |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 4-02</i>                          |  |  |
| C. Length of stay in Baltimore<br><i>?</i> Yrs. Mos. Days   |                                  |   | D. STREET ADDRESS (If rural, give location)<br><i>684 W Fayette St</i>   |  |  |
| 5. SEX<br><i>Female</i>   | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Widowed</i>   | 8. DATE OF BIRTH<br><i>?</i>   |  | 9. AGE (in years last birthday)<br><i>62</i>                             |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>?</i>   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>?</i>   | 11. BIRTHPLACE (State or foreign country)<br><i>Lith.</i>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>?</i>                                 |
| 13. FATHER'S NAME<br><i>?</i>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><i>?</i>   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>-</i>  |                                  | 16. SOCIAL SECURITY NO.<br><i>?</i>   | 17. INFORMANT ADDRESS<br><i>M. V. Velgis 749 W Baltimore St</i>  |  |  |
| 18. <i>443X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                                  |   | CAUSE OF DEATH<br>(A) <i>Cerebral Hemorrhage</i><br>DUE TO<br>(B) <i>Hypertensive Cardia Vascular disease</i><br>DUE TO<br>(C) |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>8 days</i><br><i>2</i>            |
| 19A. DATE OF OPERATION<br><i>0</i>  |                                  | 19B. MAJOR FINDINGS OF OPERATION  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <i>June 19, 1950</i> to <i>June 26, 1950</i> that I last saw the deceased alive on <i>June 26, 1950</i> and that death occurred at <i>8:10</i> m., from the causes and on the date stated above.   |                                  |   |  |  |  |
| 23A. SIGNATURE<br><i>Larry Glassman</i>   |                                  | 23B. ADDRESS<br><i>26 D7 Western Ave</i>  |  | 23C. DATE SIGNED<br><i>June 28-50</i>                                    |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |                                  | 24B. DATE<br><i>June 30 1950</i>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Holy Redeemer Cem</i>           |  |
| 24D. LOCATION (City, town or county) (State)<br><i>Belair Rd Md</i>   |                                  | 24E. FUNERAL DIRECTOR<br><i>Joseph Kasenkas Jr</i>  |  | 24F. ADDRESS<br><i>602 W Oak St</i>                                      |  |

MEDICAL CERTIFICATION

DATE RECEIVED BY LOCAL REGISTRAR  
JUN 30 1950  
VS 150

937





250

0 5748

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5748

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JUNIA JACKSON, Jr.

2. DATE  
OF  
DEATH June 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

1625 Shadyside Road.

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR  
INDUSTRY

13. FATHER'S NAME

Junia Jackson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.  
None

8. DATE OF BIRTH

Dec. 10, 1926

9. AGE (In years  
last birthday)

23

If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

England

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Ellen Gilbert

17. INFORMANT

ADDRESS

Junia Jackson, Sr., 1625 Shadyside Road

18. 592X I CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1950, to June 27, 1950, that I last saw the  
deceased alive on June 16, 1950, and that death occurred at 2:00 P.M. from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S

ADDRESS

JUN 30 1950

Huntington Williams, M.D.

William C. Paul 1211 St Paul St

WALTER  
CERTIFICATE OF DEATH

1000

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363  
5749BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5749

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>GAILEY P. STREET</b>  |                                  | 2. DATE OF DEATH <b>June 28, 1950</b>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>Baltimore</b> |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>1110 Brentwood Ave.</b>   |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>  |  |
| c. Length of stay in Baltimore<br>Yrs.<br>Mos.<br>Days  |                                  | D. STREET ADDRESS (If rural, give location)<br><b>1110 Brentwood Ave.</b>   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>   | 8. DATE OF BIRTH<br><b>Nov. 17, 1878</b>     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Sanitary Dept. Baltimore</b>  | 9. AGE (In years last birthday)<br><b>71</b> |
| 11. BIRTHPLACE (State or foreign country)<br><b>Harford County, Md.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME<br><b>Wm. H. Street</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary S. Ramplay</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>Mary C. Street, 1110 Brentwood Ave.</b>   |                                  | ADDRESS   |  |
| 18. <b>442X</b> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Anterograde Cardiac Vascular Renal Disease</b><br>DUE TO<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>?</b> |                                  |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>  |                                  | 19B. MAJOR FINDINGS OF OPERATION  |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                                  | 21D. HOW DID INJURY OCCUR?  |  |
| 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/><br>m.   |                                  |   |  |
| 22. I hereby certify that I attended the deceased from <b>6/9</b> , 19 <b>52</b> , to <b>6/28</b> , 19 <b>52</b> , that I last saw the deceased alive on <b>6/28</b> , 19 <b>50</b> , and that death occurred at <b>m.</b> , from the causes and on the date stated above.  |                                  |   |  |
| 23A. SIGNATURE<br><b>Joseph Blum</b>  |                                  | 23B. ADDRESS<br><b>1115 N. Calvert St.</b>  |  |
| 23C. DATE SIGNED<br><b>6/29/52</b>  |                                  |   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 24B. DATE<br><b>7/1/50</b>  |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>Belair Memorial Gardens</b>  |                                  | 24D. LOCATION (City, town, or county) (State)<br><b>Belair, Md.</b>   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 30 1950</b>  |                                  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b>   |  |
| 25. FUNERAL DIRECTOR<br><b>1217 S. Paul</b>   |                                  | ADDRESS<br><b>131a</b>  |  |

MEDICAL CERTIFICATION

REPORT OF THE BOARD OF DIRECTORS  
CENTRAL BANK OF THE UNITED STATES

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5750

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

5750

Registered No.

1. NAME OF DECEASED (Type or Print)

Louis Lemkuhl

2. DATE OF DEATH

June 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION

St. Paul Convalescent Home

2305 St. Paul Street

6. LENGTH OF STAY IN BALTIMORE

Yrs.

Mos.

Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

June 25, 1862

9. AGE (In years last birthday)

88

10. UNDER 1 YEAR

Months

Days

11. UNDER 24 HOURS

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Mail Carrier - Ret.

10B. KIND OF BUSINESS OR INDUSTRY

U.S. Post Office

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Charles Lemkuhl

14. MOTHER'S MAIDEN NAME

Sophia Wagner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT ADDRESS

Leland S. Lemkuhl, 1106 E. 36th Street

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(A)

Arteriosclerosis and

DUE TO

Uremia -

(B)

seizure

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES

NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21. TIME (Month) (Day) (Year) (Hour)

INJURY

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 10th, 1950, to June 26, 1950, that I last saw the deceased alive on June 28, 1950, and that death occurred at 2:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

St. Paul Convalescent Home

M. D.

23B. ADDRESS

3038 W. North Ave.

23C. DATE SIGNED

6/28/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

burial

24B. DATE

7/1/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore Maryland

DATE RECEIVED BY LOCAL REGISTRAR

JUN 30 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS

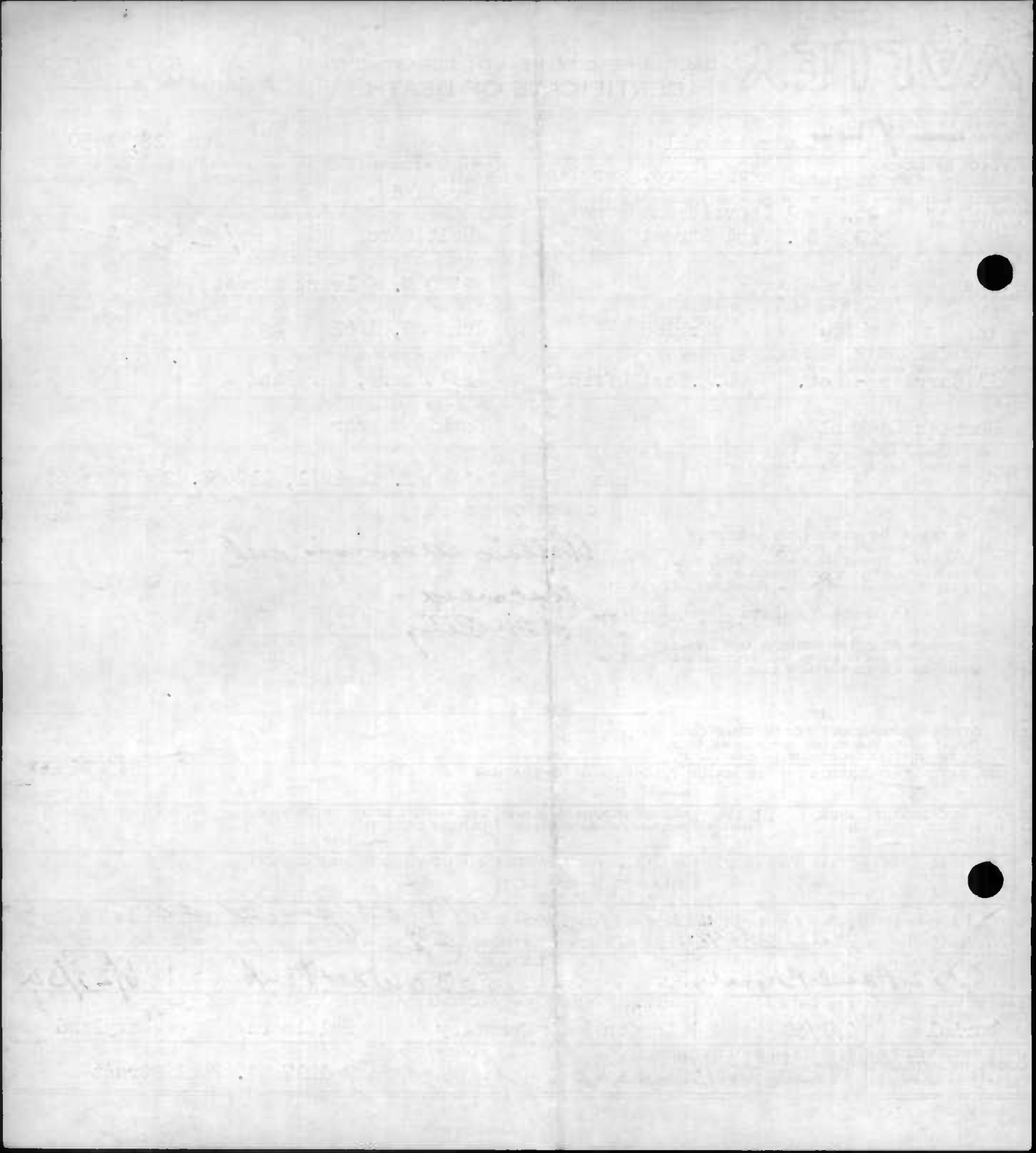
Wm. Cook, Inc., 1217 St. Paul Street

VS 150

97

MEDICAL CERTIFICATION





12

5751

BIRTH NO. 50-10058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 5751

1. NAME OF DECEASED  
(Type or Print)

2. DATE OF DEATH

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION

6. DATE OF BIRTH

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. AGE (In years last birthday)

9. LENGTH OF STAY IN BALTIMORE

10. BIRTHPLACE (State or foreign country)

11. FATHER'S NAME

12. CITIZEN OF WHAT COUNTRY?

13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

14. MOTHER'S MAIDEN NAME

15. SOCIAL SECURITY NO.

16. INFORMANT ADDRESS

17. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

18. CAUSE OF DEATH

19. INTERVAL BETWEEN ONSET AND DEATH

20. ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

22. MEDICAL CERTIFICATION

23. DATE OF OPERATION

24. MAJOR FINDINGS OF OPERATION

25. AUTOPSY?  
YES NO

26. ACCIDENT, SUICIDE, HOMICIDE (Specify)

27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office hldg., etc.)

28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

29. TIME (Month) (Day) (Year) (Hour) INJURY

30. INJURY OCCURRED  
WHILE AT WORK NOT WHILE AT WORK

31. HOW DID INJURY OCCUR?

32. I hereby certify that I attended the deceased from 5-13, 1950, to 5-14, 1950, that I last saw the deceased alive on 5-14, 1950, and that death occurred at 4:50 Pm., from the causes and on the date stated above.

33. SIGNATURE

34. ADDRESS

35. DATE SIGNED

36. BURIAL, CREMATION, REMOVAL (Specify)

37. DATE

38. NAME OF CEMETERY OR CREMATORY

39. LOCATION (City, town, or county) (State)

40. DATE RECEIVED BY LOCAL REGISTRAR

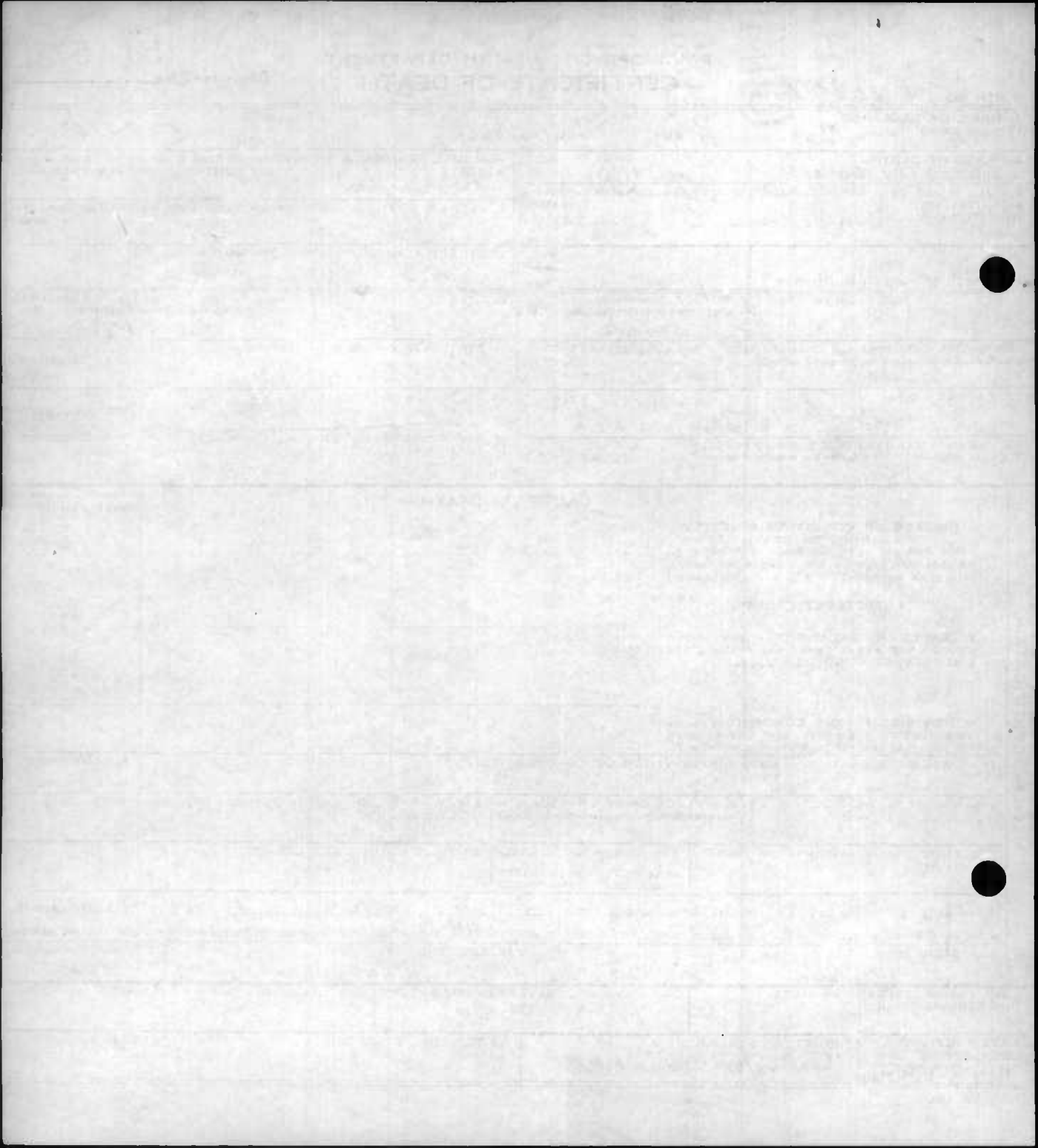
41. REGISTRAR'S SIGNATURE

42. FUNERAL DIRECTOR

43. ADDRESS

VS 150

159

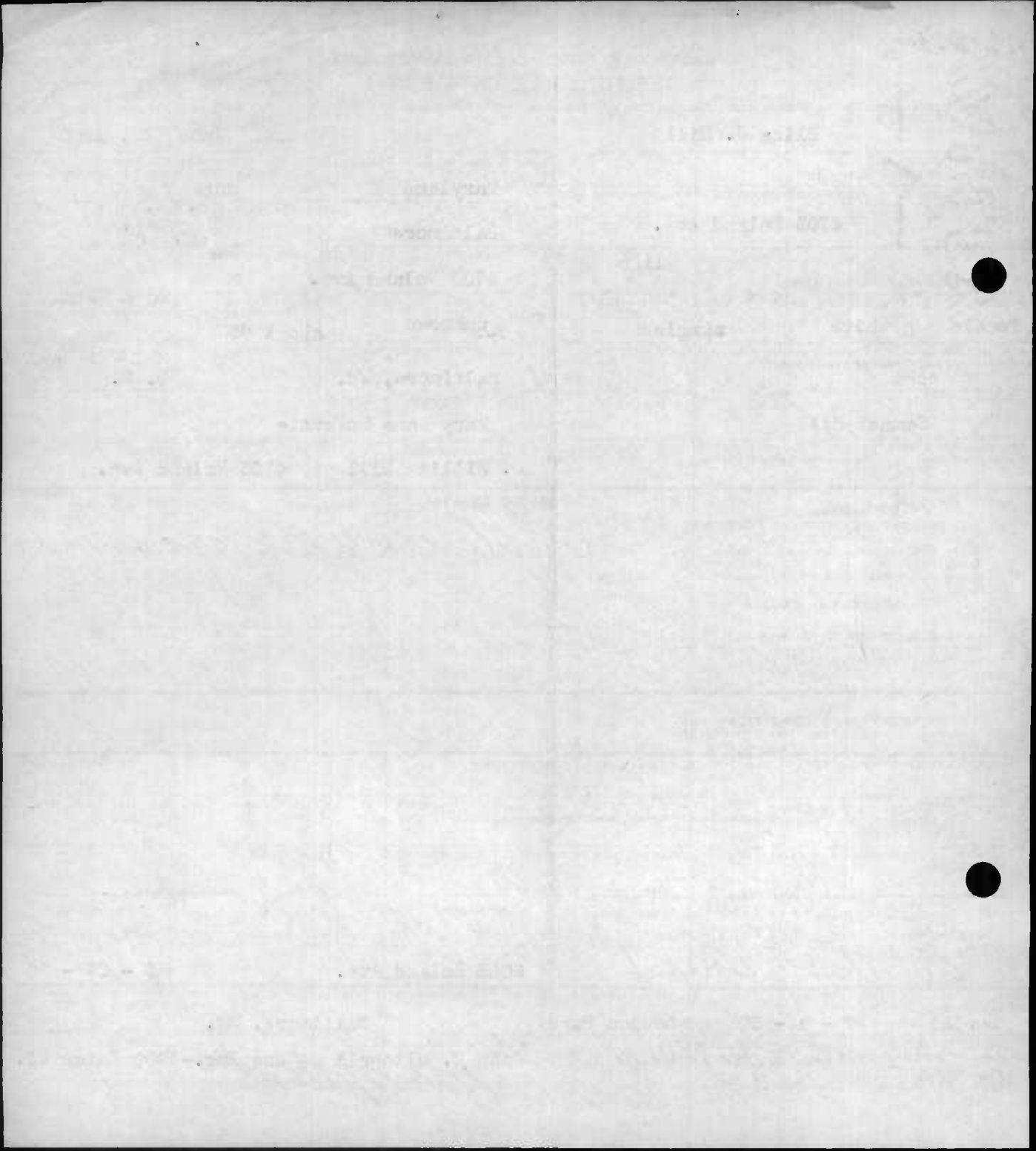


400  
50 5752BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5752  
Registered No.

|  |                                  |  |                                    |
|--|----------------------------------|--|------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Eliza J. Hill</b>  |                                  | 2. DATE OF DEATH<br><b>June 29, 1950</b>   |                                    |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>none</b> |                                    |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>4703 Roland Ave.</b>   |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>27-14</b>                              |                                    |
| C. Length of stay in Baltimore<br><b>life</b>  |                                  | D. STREET ADDRESS (If rural, give location)<br><b>4703 Roland Ave.</b>   |                                    |
| 5. SEX<br><b>female</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>single</b>   | 8. DATE OF BIRTH<br><b>unknown</b> |
| 9. AGE (in years last birthday)<br><b>about 85</b>   |                                  | 10. UNDER 1 Year Months Days<br>11. UNDER 24 Hours Hours Min.  |                                    |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>none</b> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY  |                                    |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>   |                                    |
| 13. FATHER'S NAME<br><b>Samuel Hill</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Jane McKenzie</b>  |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>no</b>                             |                                  | 16. SOCIAL SECURITY NO.  |                                    |
| 17. INFORMANT<br><b>J. William Hill</b>  |                                  | ADDRESS<br><b>4703 Roland Ave.</b>   |                                    |

|  |                                  |
|--|----------------------------------|
| 18. <b>4500</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>INTEROSCLEROSIS GENERALIZED</b><br>DUE TO<br>(A) .....<br>(B) .....<br>(C) .....<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B) .....<br>(C) .....<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | INTERVAL BETWEEN ONSET AND DEATH |
|--|----------------------------------|

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 19A. DATE OF OPERATION<br><b>0</b>  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br><b>INJURY</b>  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <b>January, 1945</b> , to <b>June, 1950</b> , that I last saw the deceased alive on <b>June 28, 1950</b> , and that death occurred at <b>2:30 p.m.</b> , from the causes and on the date stated above. |  |   |  |  |  |
| 23A. SIGNATURE<br><b>William S. Helrich</b><br>M. D.  |  | 23B. ADDRESS<br><b>5006 Roland Ave.</b>   |  | 23C. DATE SIGNED<br><b>6 - 29 - 50</b>                                   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>  |  | 24B. DATE<br><b>7 - 1 - 50</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>                 |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>  |  | 25. FUNERAL DIRECTOR<br><b>John O. Mitchell &amp; Sons, Inc.</b><br><b>1900 Eutaw Pl.</b>                 |  |  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 30 1950</b>  |  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b>   |  | ADDRESS<br><b>Dr. Helrich, after 7 P.M.</b>                              |  |



623  
5753

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5753  
Registered No.

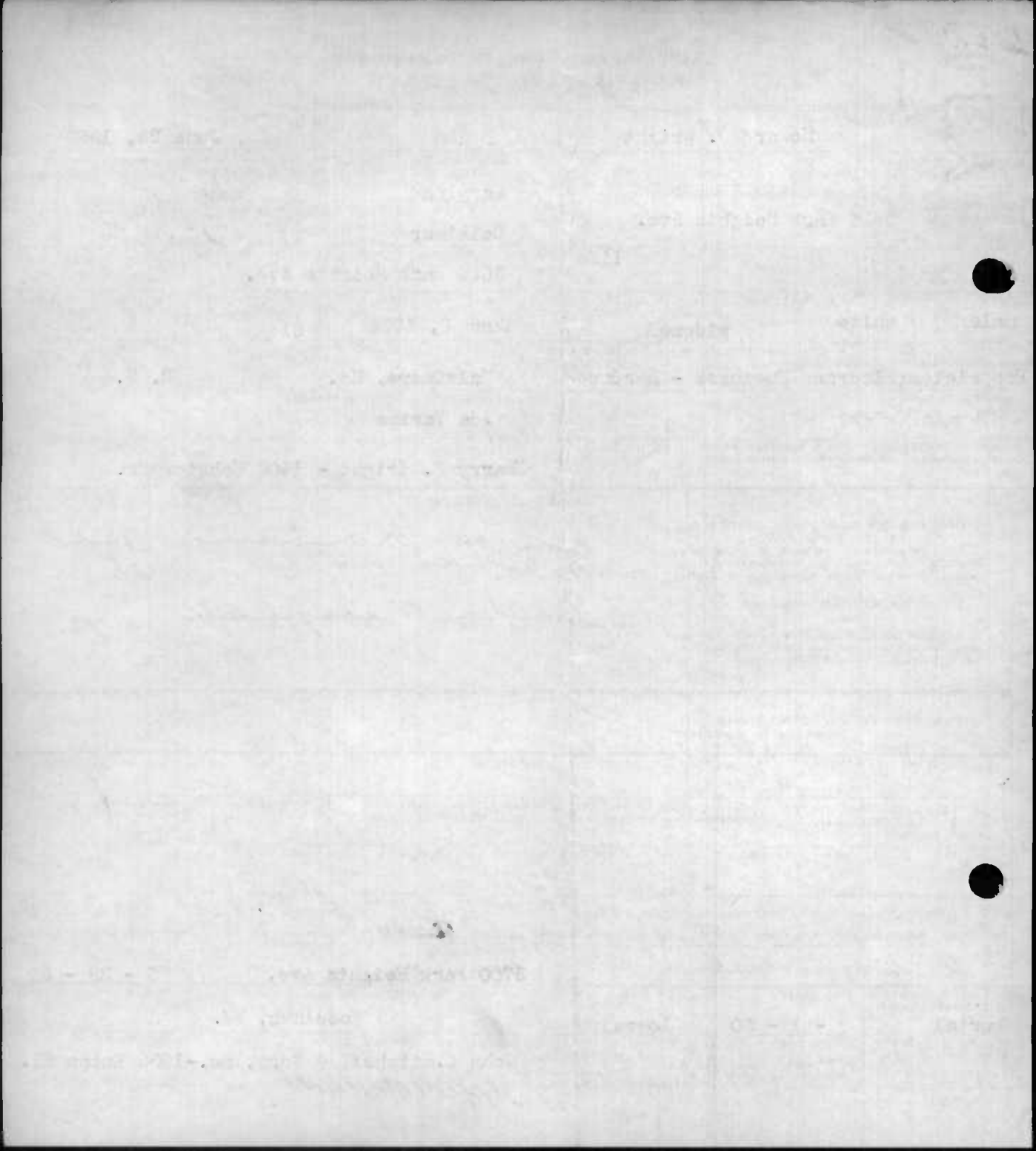
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|--|----------------------------------|---|--|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Howard O. Wright</b>   |                                  |   | 2. DATE OF DEATH <b>June 28, 1950</b>  |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  |   | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>none</b> |  |   |
| 5. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR <b>3624 Park Heights Ave.</b><br>INSTITUTION |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>15-12</b>                              |  |   |
| 6. MONTH OF BIRTH OF DECEASED <b>life</b><br>Yrs. <b>life</b><br>Mos. <b>life</b><br>Days <b>life</b>  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>3624 Park Heights Ave.</b>   |  |   |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>widowed</b> | 8. DATE OF BIRTH<br><b>June 8, 1889</b>  | 9. AGE (In years last birthday)<br><b>61</b> | 10. Under 1 Year Months: Days<br>11. Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Proprietor: Flooring Business - hardwood</b>   |                                  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>   |  |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>   |                                  |   | 13. FATHER'S NAME<br><b>Thomas Wright</b>  |  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Ida Varina</b>  |                                  |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                   |  |   |
| 16. SOCIAL SECURITY NO.  |                                  |   | 17. INFORMANT ADDRESS<br><b>Harry E. Wright - 1406 Webster St.</b>   |  |   |

|   |  |   |
|---|--|---|
| 18. <b>420.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Coronary Thrombosis.</b><br><b>arteriosclerosis.</b><br>CAUSE TO<br><b>Cardiac Decompensation</b><br>CAUSE TO |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>checked, - ?</b><br><b>1 yr.</b> |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>  |  |   |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 19A. DATE OF OPERATION <b>0</b>  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) <b>INJURY</b>  |  | 21E. INJURY OCCURRED<br>WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>Nov 7 1949</b> to <b>June 28, 1950</b> , that I last saw the deceased alive on <b>June 22, 1950</b> , and that death occurred at <b>156 R B Mitchell</b> from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE<br><b>Reuben H. Kolman</b>  |  | 23B. ADDRESS<br>M. D. <b>3700 Park Heights Ave.</b>   |  | 23C. DATE SIGNED<br><b>6 - 29 - 50</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>   |  | 24B. DATE<br><b>7 - 1 - 50</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine</b>                                     |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Woodlawn, Md.</b>  |  | 25. FUNERAL DIRECTOR ADDRESS<br><b>John O. Mitchell &amp; Sons, Inc. - 1900 Eutaw Pl.</b>                 |  |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 30 1950</b>   |  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b>   |  | 25. FUNERAL DIRECTOR ADDRESS<br><b>John O. Mitchell &amp; Sons, Inc. - 1900 Eutaw Pl.</b> |  |

VS 150  
156 R B Mitchell  
Dr. Reuben H. Kolman  
6-8 95c



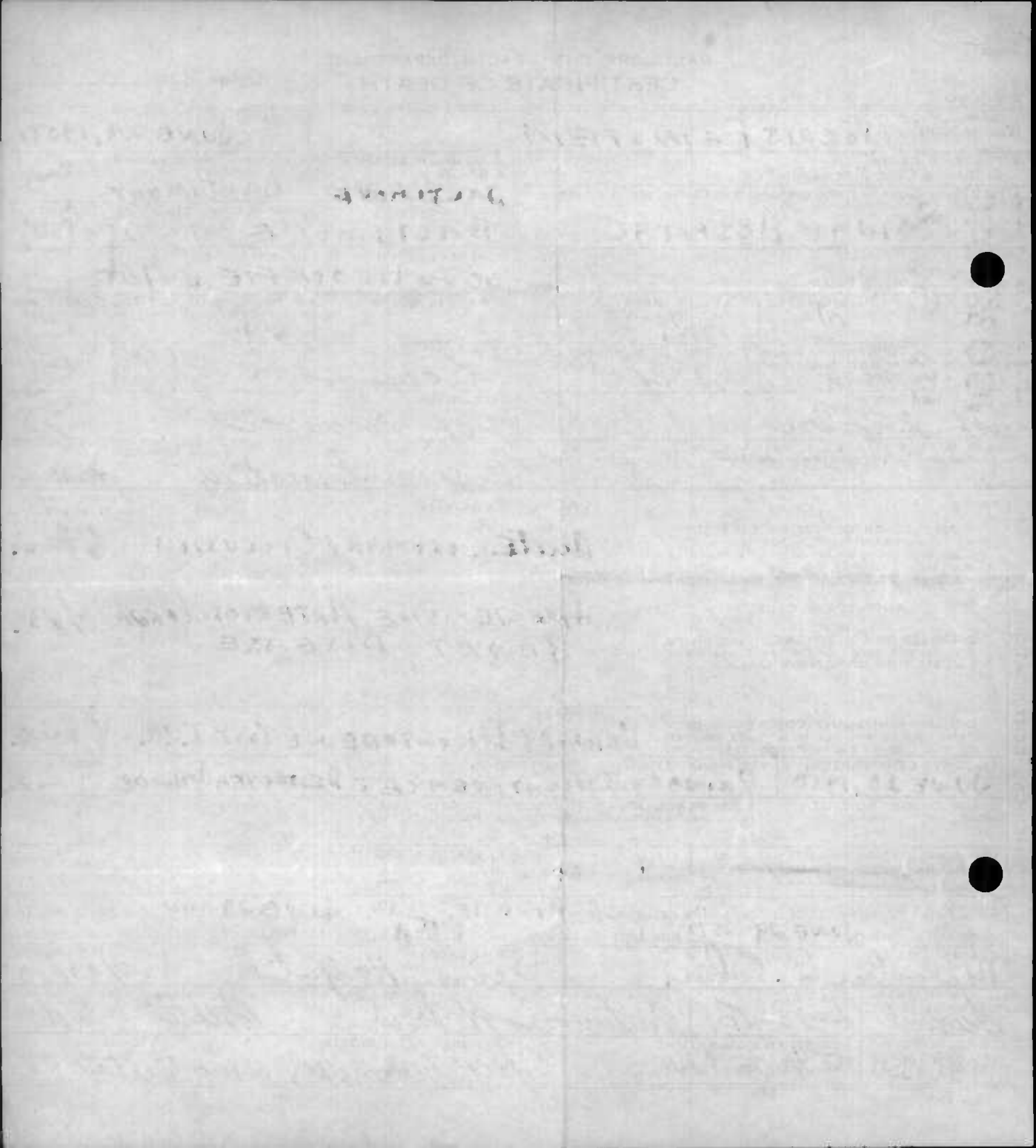


|   |                                  |   |
|---|----------------------------------|---|
| 163   | BALTIMORE CITY HEALTH DEPARTMENT | Registered No. 50 5754  |
| 50 5754   | CERTIFICATE OF DEATH             |   |
| BIRTH NO.   |                                  |   |
| 1. NAME OF DECEASED<br>(Type or Print) James B. Robertson   |                                  | 2. DATE OF DEATH June 28, 1950  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY none |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>6000 Bellona Avenue<br>Edgewood Nursing Home  |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 14-01                           |
| C. Length of stay in Baltimore 8- Mos. Days   |                                  | D. STREET ADDRESS (If rural, give location)<br>1407 John St.  |
| 5. SEX male   | 6. COLOR OR RACE white           | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married   |
| 8. DATE OF BIRTH 2 - 16 - 71  |                                  | 9. AGE (in years last birthday) 79  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>P.O. Inspector   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY   |
| 11. BIRTHPLACE (State or foreign country)<br>Delphi, Ind.   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.  |
| 13. FATHER'S NAME<br>Andrew Benson Robertson  |                                  | 14. MOTHER'S MAIDEN NAME<br>Sarah Jones   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.   |
| 17. INFORMANT Jas. B. Robertson, Jr. - 1407 John St.  |                                  | ADDRESS   |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>Anterior Myocardial Heart Disease<br>DUE TO<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>INTERVAL BETWEEN ONSET AND DEATH ? |                                  |   |
| 19A. DATE OF OPERATION 0  |                                  | 19B. MAJOR FINDINGS OF OPERATION  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                                 |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                                  |   |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |                                  | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK                    |
| 21F. HOW DID INJURY OCCUR?  |                                  |   |
| 22. I hereby certify that I attended the deceased from November 1949, to June 28, 1950, that I last saw the deceased alive on June 28, 1950, and that death occurred at 8:30 a.m., from the causes and on the date stated above.  |                                  |   |
| 23A. SIGNATURE<br>Sylvan J. Goldberg  |                                  | 23B. ADDRESS<br>Medical Arts Bldg. - 316  |
| 23C. DATE SIGNED<br>June 30, 1950   |                                  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>burial   |                                  | 24B. DATE<br>7 - 1 - 50   |
| 24C. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge   |                                  | 24D. LOCATION (City, town, or county) (State)<br>Pikesville, Md.  |
| DATE RECEIVED BY LOCAL REGISTRAR<br>JUN 30 1950   |                                  | REGISTRAR'S SIGNATURE<br>Huntington Williams, M.D.  |
| 25. FUNERAL DIRECTOR<br>John O. Mitchell & Sons, Inc. - 1900 Eutaw Pl.  |                                  | ADDRESS<br>Mr. Sylvan J. Goldberg, A.M. - 930 93D   |



523  
5755BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5755  
Registered No.

|   |                           |  |                  |
|---|---------------------------|--|------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>MORRIS FEINSTEIN</b>  |                           | 2. DATE OF DEATH <b>JUNE 29, 1950</b>  |                  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                           | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> |                  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL</b>   |                           | C. CITY OR TOWN <b>BALTIMORE</b> (If outside corporate limits, write RURAL and give township) <b>13-02</b>                                   |                  |
| c. Length of stay in Baltimore  |                           | D. STREET ADDRESS (If rural, give location) <b>2030 BROOKFIELD AVE</b>   |                  |
| 5. SEX <b>M</b>   | 6. COLOR OR RACE <b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>M</b>   | 8. DATE OF BIRTH |
| 9. AGE (In years last birthday) <b>69</b>   |                           | 10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min.  |                  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoe maker</b>   |                           | 10B. KIND OF BUSINESS OR INDUSTRY <b>self</b>  |                  |
| 11. BIRTHPLACE (State or foreign country) <b>Russia</b>   |                           | 12. CITIZEN OF WHAT COUNTRY?   |                  |
| 13. FATHER'S NAME <b>Not known</b>  |                           | 14. MOTHER'S MAIDEN NAME <b>Not known</b>  |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |                           | 16. SOCIAL SECURITY NO.  |                  |
| 17. INFORMANT <b>Bessie Feinstein</b>   |                           | ADDRESS <b>Same</b>  |                  |
| 18. <b>420.0</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>ACUTE CORONARY OCCLUSION</b><br>DUE TO<br><b>HYPERTENSIVE ARTERIOSCLEROSIS 4 YRS.</b><br>DUE TO<br><b>HEART DISEASE</b><br><b>URINARY INCONTINENCE POST T.U.R. 8 mos.</b> |                           | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 hrs.</b>  |                  |
| 19A. DATE OF OPERATION <b>JUNE 20, 1950</b>   |                           | 19B. MAJOR FINDINGS OF OPERATION <b>URINARY INCONTINENCE - DESTROYED SPHINCTER</b>   |                  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                           |  |                  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                           | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  |                  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                           |  |                  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |                           | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>                                       |                  |
| 21F. HOW DID INJURY OCCUR?  |                           |  |                  |
| 22. I hereby certify that I attended the deceased from <b>JUNE 18, 1950</b> , to <b>JUNE 29, 1950</b> , that I last saw the deceased alive on <b>JUNE 29, 1950</b> , and that death occurred at <b>6:15 pm.</b> , from the causes and on the date stated above.   |                           |  |                  |
| 23A. SIGNATURE <b>Malcolm E. Fisher</b>   |                           | 23B. ADDRESS <b>Surge Hospital</b>   |                  |
| 23C. DATE SIGNED <b>6/29/50</b>   |                           |  |                  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                           | 24B. DATE <b>6-30-50</b>   |                  |
| 24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore Hebrew</b>  |                           | 24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>  |                  |
| DATE RECEIVED BY LOCAL REGISTRAR <b>JUN 30 1950</b>   |                           | REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>   |                  |
| 25. FUNERAL DIRECTOR <b>Jack Lewis Inc</b>  |                           | ADDRESS <b>2100 Eutaw Pl</b>   |                  |



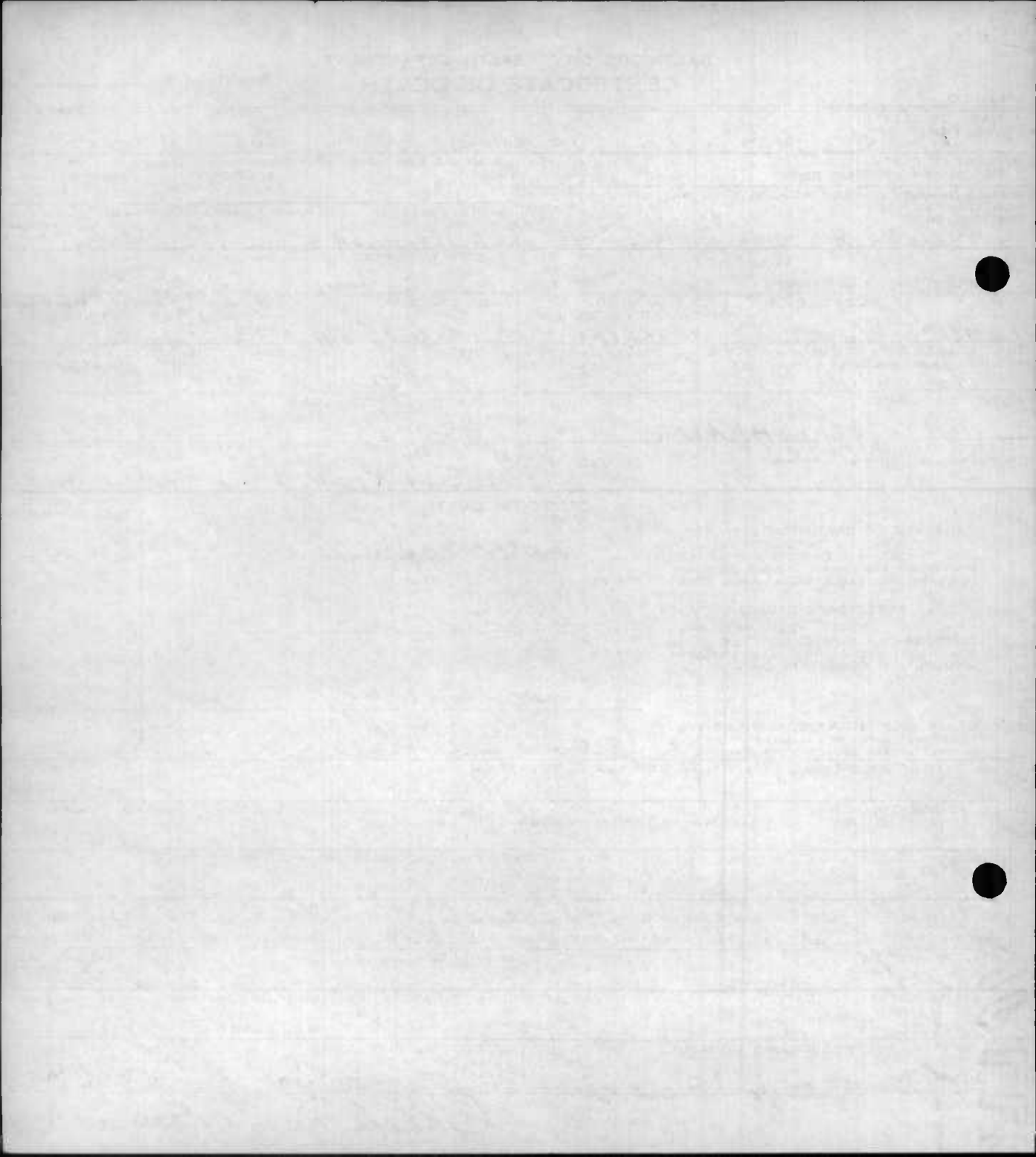
200  
50 5756BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5756  
Registered No.

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>WILLIAM H. DOSH</b>  |                                  | 2. DATE OF DEATH<br><b>June 28, 1950</b>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE<br><b>Md.</b><br>B. COUNTY |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>709 E. Gittings Ave.</b>   |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 27-08B</b>                      |  |
| C. Length of stay in Baltimore<br>Yrs. Mos. Days   |                                  | D. STREET ADDRESS (If rural, give location)<br><b>709 E. Gittings Ave.</b>   |  |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>widowed</b>  | 8. DATE OF BIRTH<br><b>May 4, 1866</b> |
| 9. AGE (In years last birthday)<br><b>84</b>   |                                  | 10. Under 1 Year Months Days<br>11. Under 24 Hours Hours Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Elec. Eng. (rtd)</b>   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Elec. Eng.</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME<br><b>Unknown</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>no</b>   |  |
| 17. INFORMANT<br><b>Mr. W. Lynn Dosh</b>   |                                  | ADDRESS<br><b>709 E. Gittings Ave.</b>   |  |
| 18. <b>4/20.0</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic Heart Disease</b><br>DUE TO<br><b>General Arteriosclerosis</b><br>DUE TO<br><b>Senility</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>none</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>14 yrs</b><br><b>1X yrs</b><br><b>1X yrs.</b>   |  |
| 19A. DATE OF OPERATION<br><b>None</b>  |                                  | 19B. MAJOR FINDINGS OF OPERATION<br><b>None</b>  |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |  |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)<br><b>None</b>  |                                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                     |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                                  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY<br><b>None</b>  |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>         |  |
| 21F. HOW DID INJURY OCCUR?   |                                  |  |  |
| 22. I hereby certify that I attended the deceased from <b>Nov 17, 1949</b> , to <b>June 28, 1950</b> , that I last saw the deceased alive on <b>June 24, 1950</b> , and that death occurred at <b>2:30 p.m.</b> , from the causes and on the date stated above.  |                                  |  |  |
| 23A. SIGNATURE<br><b>A.S. Chaffant</b>   |                                  | 23B. ADDRESS<br><b>6210 York Road</b>  |  |
| M. D.  |                                  | 23C. DATE SIGNED<br><b>June 30 1950</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 24B. DATE<br><b>6/30/50</b>  |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>Prospect Hill C em.</b>   |                                  | 24D. LOCATION (City, town, or county) (State)<br><b>Balto., Md.</b>  |  |
| DATE RECEIVED BY<br><b>JUN 30 1950</b>   |                                  | REGISTRAR'S SIGNATURE<br><b>Wm. J. Dickner</b>   |  |
| 25. FUNERAL DIRECTOR<br><b>Wm. J. Dickner</b>  |                                  | ADDRESS<br><b>937 md</b>   |  |



*[Faint handwritten notes at the bottom of the page]*

| 260  |  | KOCUR   |  | 50 5757   |  |
|--|--|---|--|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT   |  |   |  | Registered No.  |  |
| CERTIFICATE OF DEATH   |  |   |  |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>KOCUR, Sally (SALOMEA)</u>   |  |   |  | 2. DATE OF DEATH<br><u>6/27/50</u>  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |  |   |  | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <u>MD.</u><br>B. COUNTY <u>1-03</u> |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><u>36 Franklin Square Hospital</u>  |  |   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)<br><u>Baltimore</u>                                     |  |
| C. Length of stay in Baltimore<br>Yrs. <u>0</u> Mos. <u>0</u> Days <u>0</u>  |  |   |  | D. STREET ADDRESS (If rural, give location)<br><u>635 S. MONTFORD AVENUE</u>  |  |
| 5. SEX<br><u>FEMALE</u>  |  | 6. COLOR OR RACE<br><u>WHITE</u>  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><u>MARRIED</u>   |  |
| 8. DATE OF BIRTH<br><u>NOVEMBER 2 1896</u>   |  | 9. AGE (In years last birthday)<br><u>73</u>  |  | 10. Under 1 Year Months: Days<br>11. Under 24 Hours Hours: Min.   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>  |  |   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>—</u>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>POLAND</u>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>—</u>  |  |
| 13. FATHER'S NAME<br><u>MATEUSZ LAKAWA</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>AGNES</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><u>—</u>  |  |   |  | 16. SOCIAL SECURITY NO.<br><u>—</u>   |  |
| 17. INFORMANT<br><u>MR. JOHN KOCUR</u>   |  |   |  | ADDRESS<br><u>635 S. MONTFORD AVE</u>   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><u>584X I</u><br>DUE TO<br>(A) <u>Bronchopneumonia</u><br>(B) <u>Jaunderie</u><br>(C) <u>Common duct stone</u><br>DUE TO<br><u>Chronic obstructive C.U.D.</u> |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u>   |  |
| 19A. DATE OF OPERATION<br><u>0</u>   |  |   |  | 19B. MAJOR FINDINGS OF OPERATION<br><u>—</u>  |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)<br><u>—</u>   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br><u>—</u>     |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><u>—</u>  |  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br><u>—</u>  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?<br><u>—</u>  |  |
| 22. I hereby certify that I attended the deceased from <u>June 26, 1950</u> to <u>June 27, 1950</u> , that I last saw the deceased alive on <u>June 27, 1950</u> , and that death occurred at <u>6:15 P.m.</u> , from the causes and on the date stated above.   |  |   |  |   |  |
| 23A. SIGNATURE<br><u>Franklin S. G. Hoy</u>  |  | 23B. ADDRESS<br><u>Franklin S. G. Hoy</u>   |  | 23C. DATE SIGNED<br><u>6-27-50</u>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |  | 24B. DATE<br><u>7/1/50</u>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><u>HOLY ROSARY</u>  |  |
| 24D. LOCATION (City, town, or county) (State)<br><u>BALTIMORE, MD</u>  |  | 25. FUNERAL DIRECTOR<br><u>M. F. SADOWSKI &amp; SONS</u>  |  | ADDRESS<br><u>1808 EASTERN AVE</u>  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><u>JUN 30 1950</u>   |  | REGISTRAR'S SIGNATURE<br><u>Washington Williams, M.D.</u>   |  | 25. FUNERAL DIRECTOR<br><u>Charles D. Sadowski</u>  |  |
| VS 150   |  |   |  |   |  |



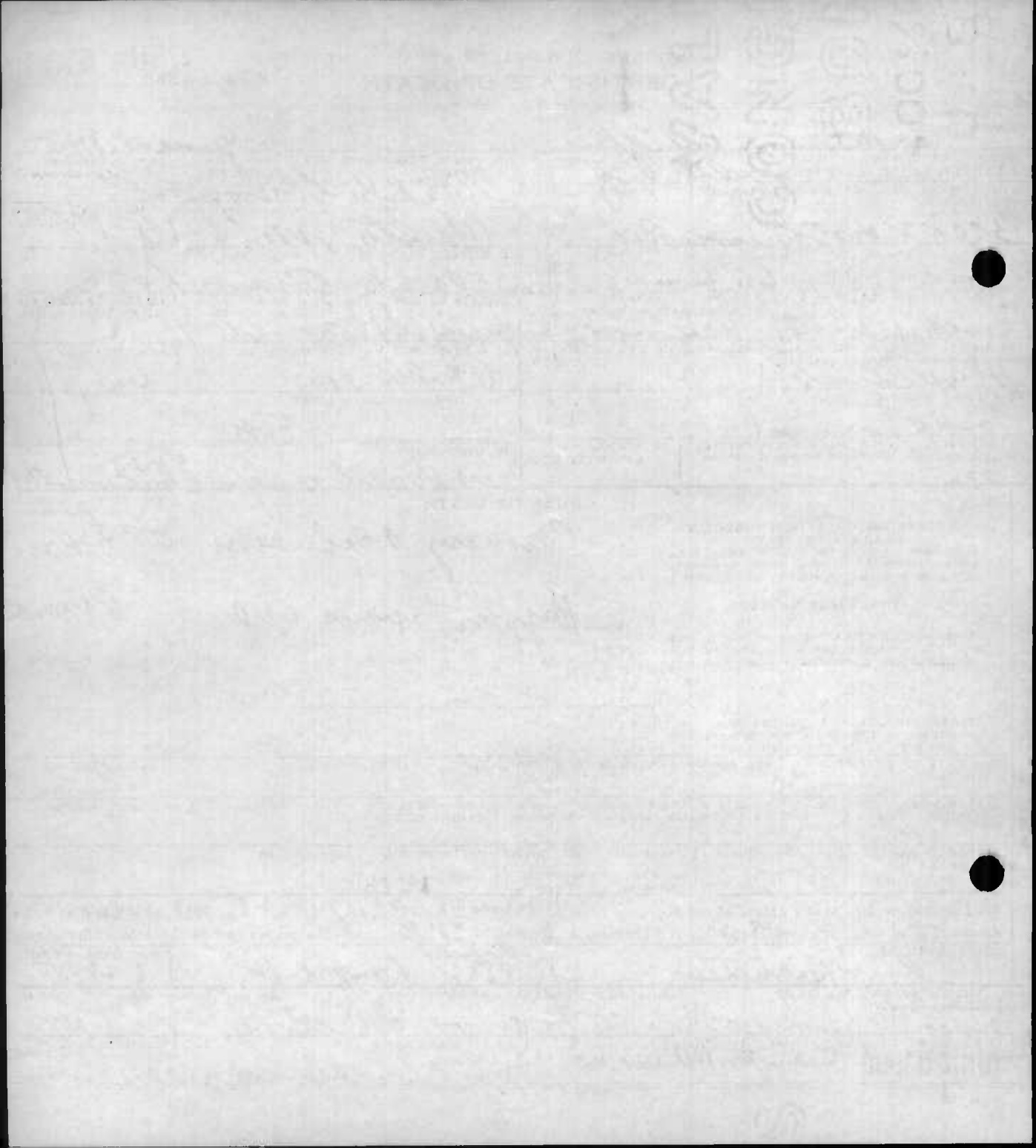
324

50-57501

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5758

|  |                                  |   |  |   |   |
|--|----------------------------------|---|--|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Rose Frank Hutzler</i>   |                                  |   | 2. DATE OF DEATH <i>June 28, 1950</i>  |   |   |
| 3. PLACE OF DEATH:<br>a. Baltimore City, Maryland <i>Balt City</i>   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <i>MD</i> B. COUNTY <i>Calvert</i> |   |   |
| b. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>3808 Chatham Rd</i>  |                                  |   | c. CITY OR TOWN (If outside corporate limits, write KURAT, and give township)<br><i>Balt Md 15-10</i>                                |   |   |
| c. Length of stay in Baltimore <i>66 years</i>   |                                  |   | d. STREET ADDRESS (If rural, give location)<br><i>3808 Chatham Rd</i>  |   |   |
| 5. SEX<br><i>Female</i>  | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Widowed</i> | 8. DATE OF BIRTH<br><i>July 16, 1883</i>   | 9. AGE (In years; last birthday)<br><i>66</i> | 10. Under 1 Year<br>Months: <i>11</i> Days: <i>17</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>House Work</i>   |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY  |   |   |
| 11. FATHER'S NAME<br><i>Louis Frank</i>  |                                  |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>US</i>  |   |   |
| 13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><i>no</i>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><i>Stein</i>   |   |   |
| 15. SOCIAL SECURITY NO.<br><i>no</i>   |                                  |   | 16. INFORMANT<br><i>Miss Horrie Hutzler</i>  |   |   |
| 17. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Coronary Occlusion</i>                                 |                                  |   | 18. INTERVAL BETWEEN ONSET AND DEATH<br><i>about 7 hrs.</i>  |   |   |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><i>Hypertensive C.V.D.</i>   |                                  |   | 20. 6 months   |   |   |
| 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                                  |   |  |   |   |
| 22. I hereby certify that I attended the deceased from <i>June 28, 1950</i> , to <i>June 28, 1950</i> , that I last saw the deceased alive on <i>June 28, 1950</i> , and that death occurred at <i>9:30 P.m.</i> , from the causes and on the date stated above. |                                  |   |  |   |   |
| 23a. SIGNATURE<br><i>G. Highstein</i>  |                                  |   | 23b. ADDRESS<br><i>888 W. Lombard St.</i>  |   |   |
| 23c. DATE SIGNED<br><i>6-29-50</i>   |                                  |   |  |   |   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                                  |   | 24b. DATE<br><i>June 30, 1950</i>  |   |   |
| 24c. NAME OF CEMETERY OR CREMATORY<br><i>Beltz Hebrew</i>  |                                  |   | 24d. LOCATION (City, town, or county) (State)<br><i>Belair Rd Md</i>   |   |   |
| 25. FUNERAL DIRECTOR<br><i>Winington Williams, Inc.</i>  |                                  |   | 26. ADDRESS<br><i>1902 East Ave</i>  |   |   |



155  
50 5759BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5759  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

George F. Hoffman

2. DATE  
OF  
DEATH

June 29 1950

3. PLACE OF DEATH:  
A. Baltimore City, MarylandB. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

University Hospital

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

28-02

D. STREET ADDRESS (If rural, give location)

4207 Ethland Ave.

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

9. AGE (In years,  
last birthday)10 Under 1 Year  
Months Days11 Under 24 Hours  
Hours Min.

84

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Henry Hoffman

14. MOTHER'S MAIDEN NAME

Rosalie Witter (WITLER)

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Geo Hoffman 4207 Ethland

18. 561.0

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Aspiration of Vomitus.  
Postoperatively

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Arteriosclerotic cardio-vascular Disease

19A. DATE OF OPERATION

June 28 1950

19B. MAJOR FINDINGS OF OPERATION

strangulated rt inguinal hernia

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 28, 1950, to June 29, 1950, that I last saw the deceased alive on June 29, 1950, and that death occurred at 6:29 A.M., from the causes and on the date stated above.

23A. SIGNATURE

H. Peterson Mack

23B. ADDRESS

M. D.

University Hospital

23C. DATE SIGNED

June 29 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

9/3/50

24C. NAME OF CEMETERY OR CREMATORY

Cathedral

24D. LOCATION (City, town, or county) (State)

Old Frederick Rd

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

J. J. Fisher, Jr. 1318 Taylor

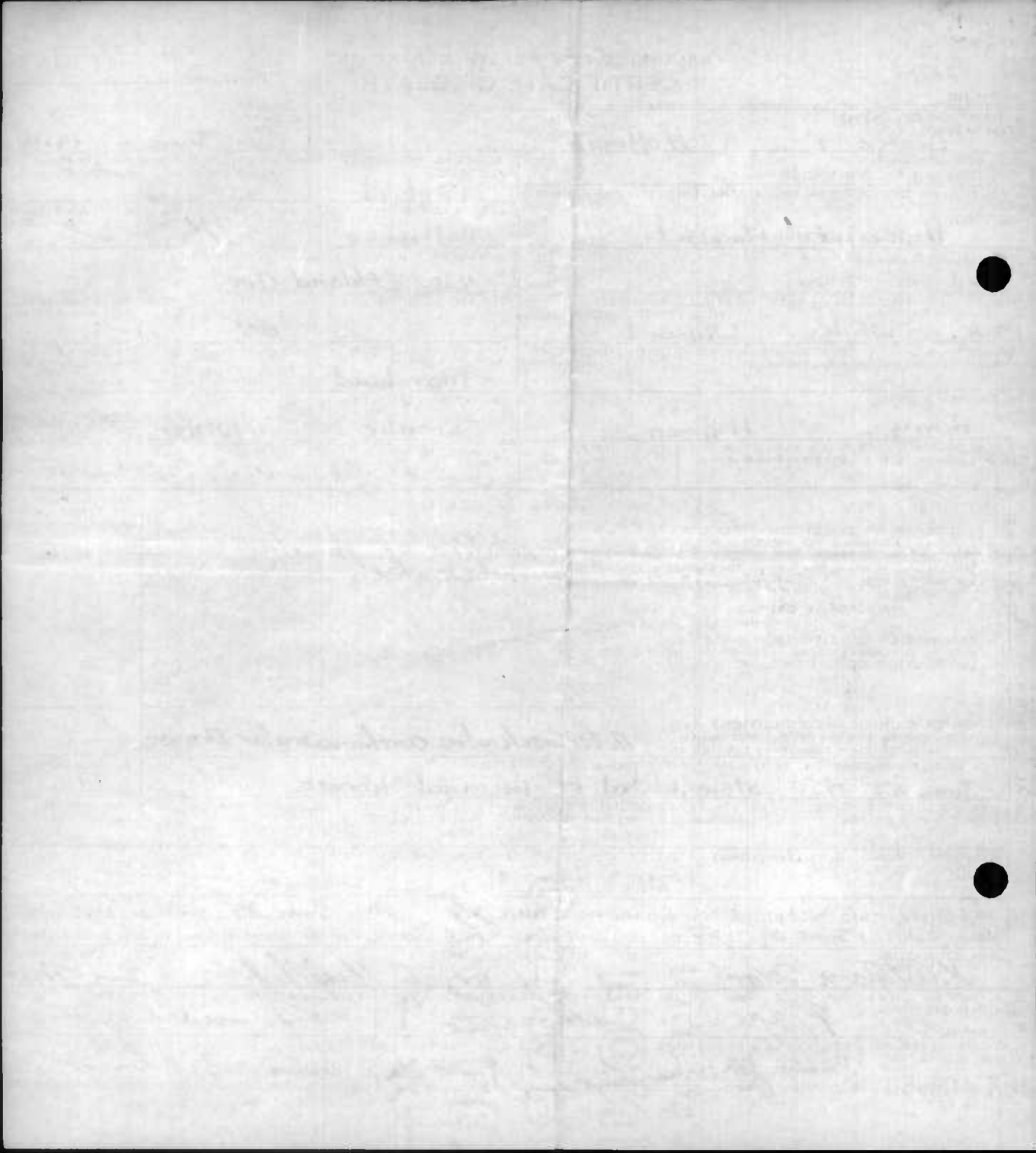
JUN 30 1950

VS 150

122a

MEDICAL CERTIFICATION





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56  
5760

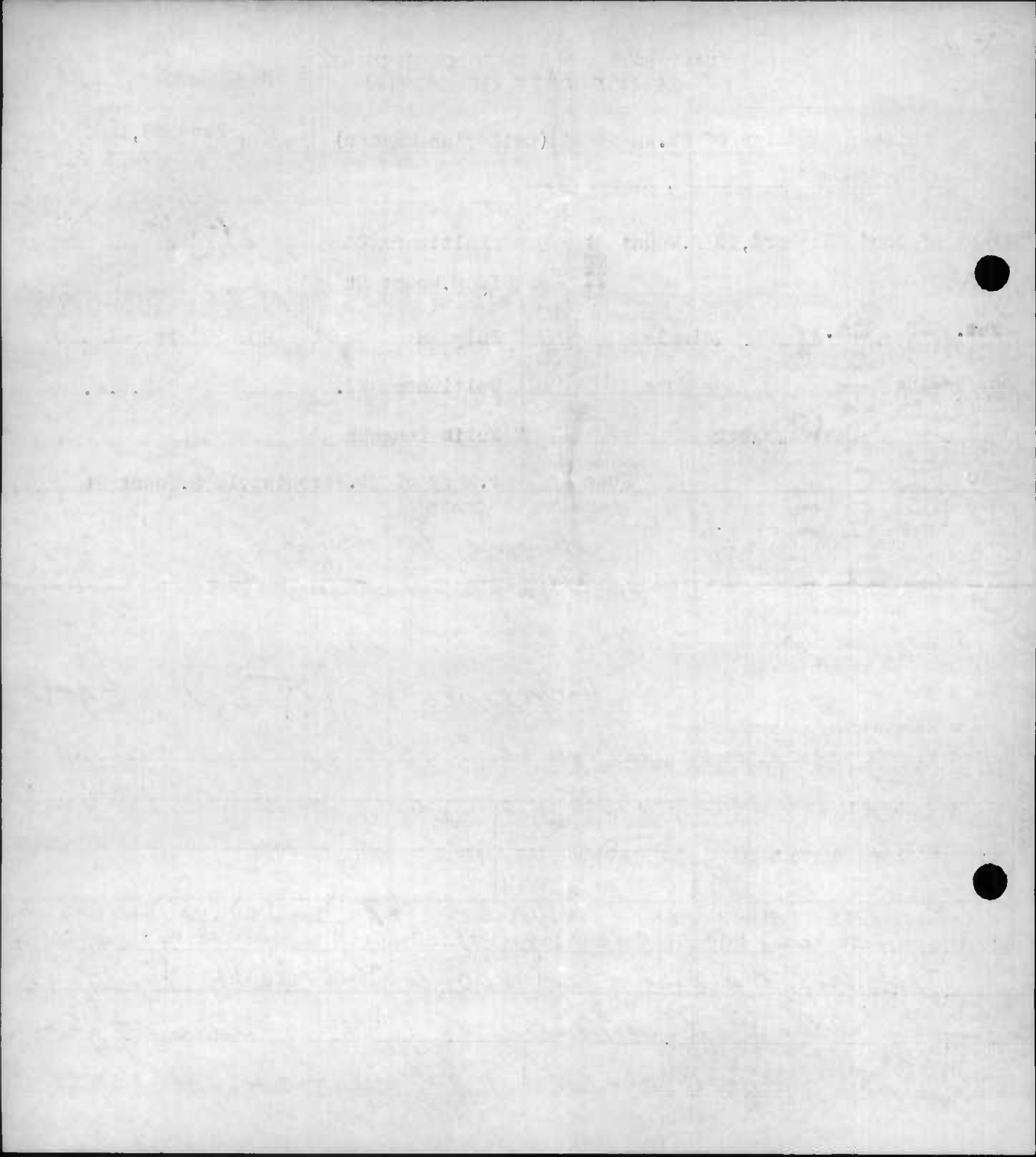
50 5760

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

|   |  |                                 |  |   |  |                                    |  |  |  |  |  |  |  |  |  |
|---|--|---------------------------------|--|---|--|------------------------------------|--|--|--|--|--|--|--|--|--|
| BIRTH NO. _____   |  |                                 |  | 1. NAME OF DECEASED<br>(Type or Print) <b>Sister Magdalen of St. Anastasia (Catherine Magner)</b>                       |  |                                    |  | 2. DATE OF DEATH<br><b>June 28, 1950</b>   |  |  |  |  |  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |  |                                 |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE _____ B. COUNTY _____ |  |                                    |  |  |  |  |  |  |  |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>Convent of Good Shepherd, 15 S. Mount St</b>   |  |                                 |  | C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)<br><b>Baltimore 23</b>                    |  |                                    |  |  |  |  |  |  |  |  |  |
| C. Month of stay in Baltimore<br><b>80</b> Yrs. <b>II</b> Mos. <b>21</b> Days   |  |                                 |  | D. STREET ADDRESS (If rural, give location)<br><b>15 S. Mount St</b>  |  |                                    |  |  |  |  |  |  |  |  |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>Wht.</b> |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>single</b>  |  | 8. DATE OF BIRTH<br><b>July 28</b> |  | 9. AGE (In years last birthday)<br><b>80</b>   |  | 10. Under 1 Year Months: <b>II</b> Days: <b>21</b> |  | 11. Under 24 Hours Hours: _____ Min: _____                             |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Home Sewing</b>   |  |                                 |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |  |                                    |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore Md.</b>                    |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                          |  |  |  |
| 13. FATHER'S NAME<br><b>David Magner</b>  |  |                                 |  |   |  |                                    |  | 14. MOTHER'S MAIDEN NAME<br><b>Julia Lenehan</b>                                     |  |  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>No</b>  |  |                                 |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  |                                    |  | 17. INFORMANT ADDRESS<br><b>Sr. Mary of St. Veronica, 15 S. Mount St</b>             |  |  |  |  |  |  |  |
| 18. <b>421.4</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Chronic Endocarditis</b><br>DUE TO <b>Hypertension</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>5 yrs.</b> |  |                                 |  | CAUSE OF DEATH<br>(A) _____<br>(B) _____<br>(C) <b>Paralysis Agitans</b><br><b>3 yrs.</b>                               |  |                                    |  |  |  |  |  |  |  |  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |                                 |  |   |  |                                    |  |  |  |  |  |  |  |  |  |
| 19A. DATE OF OPERATION<br><b>0</b>  |  |                                 |  | 19B. MAJOR FINDINGS OF OPERATION<br><b>—</b>  |  |                                    |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)<br><b>—</b>  |  |                                 |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br><b>—</b>                   |  |                                    |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>—</b> |  |  |  |  |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>INJURY<br><b>—</b>   |  |                                 |  | 21E. INJURY OCCURRED<br>WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK<br><b>—</b>   |  |                                    |  | 21F. HOW DID INJURY OCCUR?<br><b>—</b>   |  |  |  |  |  |  |  |
| 22. I hereby certify that I attended the deceased from <b>June 27, 1950</b> , to <b>June 28, 1950</b> , that I last saw the deceased alive on <b>June 27, 1950</b> , and that death occurred at <b>1:30 P. M.</b> , from the causes and on the date stated above.   |  |                                 |  |   |  |                                    |  |  |  |  |  |  |  |  |  |
| 23A. SIGNATURE<br><b>G. A. Strauss</b>  |  |                                 |  | 23B. ADDRESS<br>M. D. <b>1800 N Charles St</b>  |  |                                    |  | 23C. DATE SIGNED<br><b>6/29/50</b>   |  |  |  |  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |                                 |  | 24B. DATE<br><b>6/30/50</b>   |  |                                    |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Catharine</b>                               |  |  |  | 24D. LOCATION (City, town, or county) (State)<br><b>near Dundee Rd</b> |  |  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 30 1950</b>  |  |                                 |  | REGISTRAR'S SIGNATURE<br><b>Wm. Williams, Jr.</b>   |  |                                    |  | 25. FUNERAL DIRECTOR<br><b>J. J. Zady</b>  |  |  |  | ADDRESS<br><b>1318 Light St</b>  |  |  |  |

MEDICAL CERTIFICATION



162  
5761BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5761  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Annie Jeffries

2. DATE  
OF  
DEATH

JUN 28 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE Md B. COUNTY 7-05 before admission)C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
BaltimoreD. STREET ADDRESS (If rural, give location)  
632 W. Dallas ST

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (in years  
last birthday) 50If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY11. BIRTHPLACE (State or foreign country)  
Richmond Va.12. CITIZEN OF  
WHAT COUNTRY?13. FATHER'S NAME  
unknown14. MOTHER'S MAIDEN NAME  
Fannie15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 443X I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Cerebral hemorrhage

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

Hypertensive + arteriosclerotic  
Cardio-vascular diseaseII  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-26-1950 to 6-28-1950, that I last saw the  
deceased alive on 6-28-1950, and that death occurred at 12:30 m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

William W. Winterkill

M. D.

JOHNS HOPKINS HOSPITAL

6-29-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUN 30 1950

Huntington Williams, M.D.

Mrs. Robert A. Elliott, Daughter

1129 N. Caroline St

931

Cerebral hemorrhage

Hypertension + arteriosclerosis  
Cardiovascular disease

Box 100

William H. H. H. H.

500  
5762BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5762  
Registered No.

|   |                  |  |                  |  |  |
|---|------------------|--|------------------|--|--|
| BIRTH NO.   |                  | 1. NAME OF DECEASED<br>(Type or Print)   |                  | 2. DATE OF DEATH   |  |
|   |                  | George William Schaum  |                  | June 28-1950   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY |                  |  |  |
| 5. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION   |                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)   |                  |  |  |
| 3303 Leuckert Ave   |                  | Baltimore  |                  |  |  |
| c. Length of stay in Baltimore  |                  | D. STREET ADDRESS (If rural, give location)  |                  |  |  |
|   |                  | 3303 Leuckert Avenue   |                  |  |  |
| 6. SEX  | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  | 8. DATE OF BIRTH | 9. AGE (In years, last birthday)   | 10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min. |
| male  | white            | married  | Nov. 9-1871      | 78   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                  | 10B. KIND OF BUSINESS OR INDUSTRY  |                  | 11. BIRTHPLACE (State or foreign country)  |  |
| owner Grocery store   |                  |  |                  | Baltimore Md.  |  |
| 13. FATHER'S NAME   |                  | 14. MOTHER'S MAIDEN NAME   |                  |  |  |
| Christian John Schaum   |                  | Amelia Schilling   |                  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)   |                  | 16. SOCIAL SECURITY NO.  |                  | 17. INFORMANT ADDRESS  |  |
| Yes, no or unknown  |                  |  |                  | Mrs. Annie M. Schaum, Same   |  |
| 18. 422.2 I DISEASE OR CONDITION LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                     |                  | CAUSE OF DEATH   |                  | INTERVAL BETWEEN ONSET AND DEATH   |  |
|   |                  | (A) Acute Congestive heart failure.  |                  | 6 hours.   |  |
| ANTECEDENT CAUSES   |                  | (B) Chronic Myocardial disease   |                  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |                  | (C) ...  |                  |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                  |  |                  |  |  |
| 19A. DATE OF OPERATION  |                  | 19B. MAJOR FINDINGS OF OPERATION   |                  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                            |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)         |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                  | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK               |                  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from April 1950, to June 28, 1950, that I last saw the deceased alive on 19, and that death occurred at 11:20 p.m., from the causes and on the date stated above. |                  |  |                  |  |  |
| 23A. SIGNATURE  |                  | 23B. ADDRESS   |                  | 23C. DATE SIGNED   |  |
| James E. White  |                  | 5314 Nayford Rd  |                  | 29 June 50   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   |                  | 24B. DATE  |                  | 24C. NAME OF CEMETERY OR CREMATORY   |  |
| Burial  |                  | 7/3/50   |                  | London Park  |  |
| DATE RECEIVED BY LOCAL REGISTRAR  |                  | REGISTRAR'S SIGNATURE  |                  | 25. FUNERAL DIRECTOR ADDRESS   |  |
| JUN 30 1950   |                  | Huntington Williams, M.D.  |                  | Leonard J. Luck, 5305 Nayford  |  |





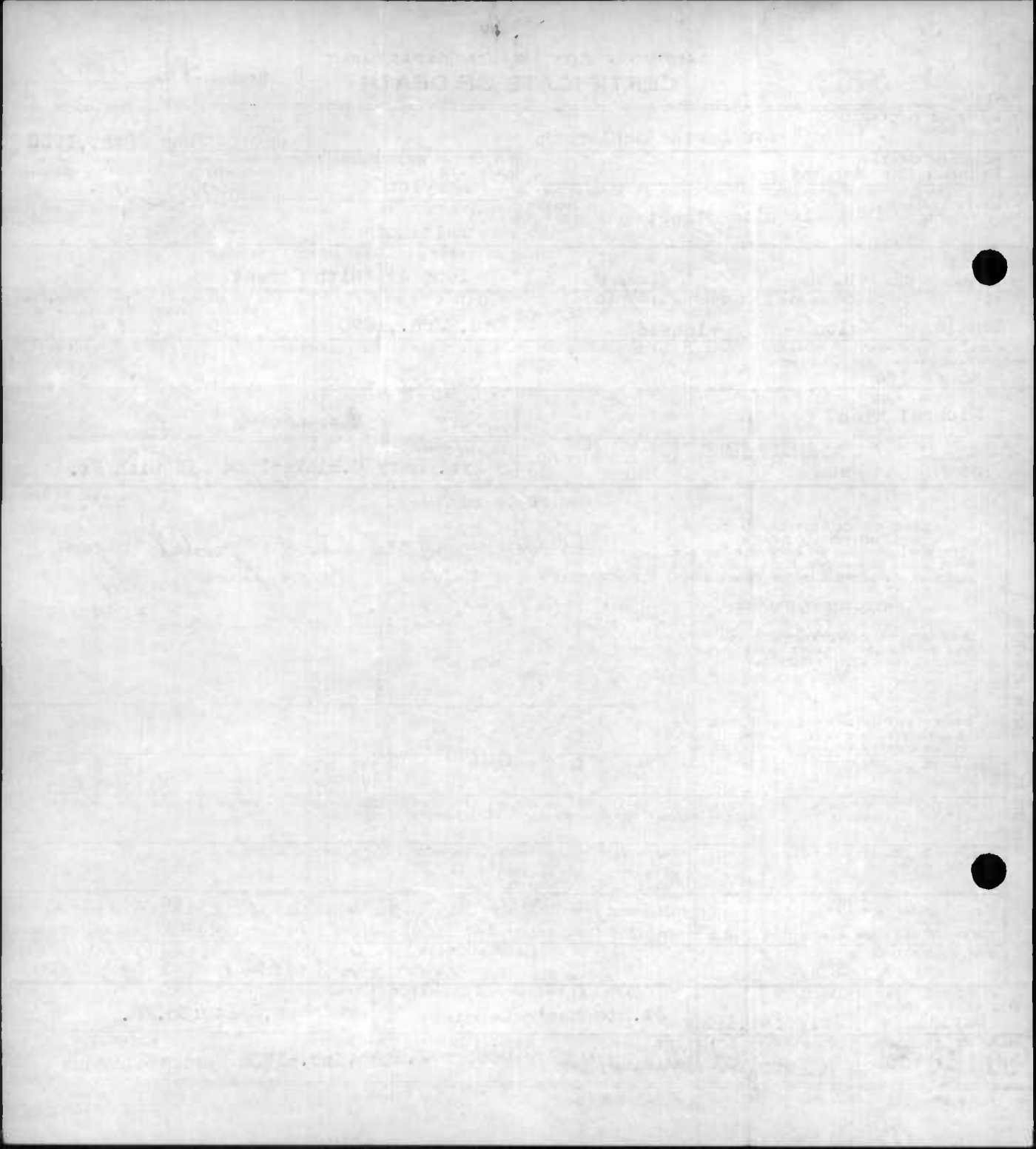
463

50 5763

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5763

|   |                                  |   |  |   |   |
|---|----------------------------------|---|--|---|---|
| BIRTH NO.   |                                  | 1. NAME OF DECEASED<br>(Type or Print) <b>Eva Bertha Schlereth</b>  |  | 2. DATE OF DEATH <b>June 28th., 1950</b>  |   |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>  |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>9-09</b> |  |   |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>1604 Aisquith Street</b>   |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>  |  |   |   |
| C. Length of stay in Baltimore <b>6 yrs.</b>  |                                  | D. STREET ADDRESS (If rural, give location)<br><b>1604 Aisquith Street</b>  |  |   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b>   |  | 8. DATE OF BIRTH<br><b>Dec. 23rd., 1870</b>   | 9. AGE (In years last birthday) <b>79</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Germany</b>                         |   |
| 13. FATHER'S NAME<br><b>Michael Klan</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary (Unknown)</b>                                   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT ADDRESS<br><b>Mrs. Mary C. Blake-1604 Aisquith St.</b>                |   |
| 18. <b>422.1 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Chronic myocardial degeneration</b><br>DUE TO<br><b>atherosclerosis</b> |                                  | CAUSE OF DEATH  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 years</b>                                  |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |                                  | (B)   |  | (C)   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                                  |   |  |   |   |
| 19A. DATE OF OPERATION <b>0</b>   |                                  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |   |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                               |  | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I hereby certify that I attended the deceased from <b>March 9, 1950</b> , to <b>June 4, 1950</b> , that I last saw the deceased alive on <b>June 4, 1950</b> , and that death occurred at <b>4:15 p.m.</b> , from the causes and on the date stated above.                                      |                                  |   |  |   |   |
| 23A. SIGNATURE<br><b>Rosenbaum</b>  |                                  | 23B. ADDRESS<br><b>120 E. D. St.</b>  |  | 23C. DATE SIGNED<br><b>6/29/50</b>  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 24B. DATE<br><b>July 1st. 1950</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>St. Stephen's Cemetery</b>                 |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 24B. DATE<br><b>July 1st. 1950</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>St. Stephen's Cemetery</b>                 |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Bradshaw, Balto: Co. Md.</b>  |                                  | 24E. FUNERAL DIRECTOR<br><b>George J. Ruth, Inc.</b>  |  | 24F. ADDRESS<br><b>-1735 Harford Avenue</b>   |   |
| DATE RECEIVED BY<br><b>JUN 30 1950</b>  |                                  | REGISTRAR'S SIGNATURE<br><b>Wm. J. Williams, M.D.</b>   |  | 25. FUNERAL DIRECTOR<br><b>George J. Ruth, Inc.</b>                                 |   |



246

50 5764

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5764

Registered No.

|   |                           |   |                                 |
|---|---------------------------|---|---------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>BABY BOY FESLER</b>                               |                           | 2. DATE OF DEATH <b>6-29-50</b>   |                                 |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                           | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>Balt.</b> |                                 |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>University Hosp.</b>                          |                           | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Balt.</b>  |                                 |
| c. Length of stay in Baltimore <b>7-2</b> Yrs. Mos. Days                                    |                           | D. STREET ADDRESS (If rural, give location)<br><b>7042 Surrey Dr. 27-20</b>   |                                 |
| 5. SEX <b>M</b>   | 6. COLOR OR RACE <b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)   | 8. DATE OF BIRTH <b>6-22-50</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |                           | 10B. KIND OF BUSINESS OR INDUSTRY   |                                 |
| 13. FATHER'S NAME <b>Herb Fesler</b>  |                           | 14. MOTHER'S MAIDEN NAME <b>Louis Cooper</b>  |                                 |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>not</b>                |                           | 16. SOCIAL SECURITY NO.   |                                 |
| 17. INFORMANT   |                           | ADDRESS   |                                 |

|   |                |  |
|---|----------------|--|
| 18. <b>776X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Prematurity</b><br>DUE TO | CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH<br><b>7d.</b> |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO<br>(B)<br>DUE TO<br>(C)  |                |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                |  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 19A. DATE OF OPERATION <b>0</b>   |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>6-22-1950</b> , to <b>6-29-1950</b> , that I last saw the deceased alive on <b>6-29-1950</b> , and that death occurred at <b>11:25 P.m.</b> , from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE<br><b>Herbert K. Spurr</b> M. D.   |  | 23B. ADDRESS<br><b>University Hosp.</b>   |  | 23C. DATE SIGNED<br><b>6-29-50</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Post Cemetery</b>                          |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Fort Meade Md</b>   |  | 24E. DATE RECEIVED BY REGISTRAR<br><b>8/30/50</b>   |  | 24F. REGISTRAR'S SIGNATURE<br><b>Wilmington Williams, M.D.</b>                      |  |
| 24G. DATE RECEIVED BY REGISTRAR<br><b>8/30/50</b>   |  | 24H. REGISTRAR'S SIGNATURE<br><b>Frank H. Newell</b>  |  | 24I. FUNERAL DIRECTOR<br><b>Pikeville, Md.</b>                                      |  |

Home in Bealston Rd, Pekesville  
Cityrude. + Huntby Home in County

## BALTIMORE CITY HEALTH DEPARTMENT

50 5765

Registered No.

## CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)KATHERINE KoloDZIEJ  
Katarynij Koloziej2. DATE  
OF  
DEATH

6/29/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Maryland General Hosp.

4. USUAL RESIDENCE (Where deceased lived: If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 1-05D. STREET ADDRESS (If rural, give location)  
130 S Patterson Park Ave 31

C. Length of stay in Baltimore

38 Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Separated

8. DATE OF BIRTH

Nov. 26-1883

9. AGE (In years  
last birthday)

67

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

GARBAR

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If Yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Walter Kolodziej 2133 Cambridge at

18. 420.0

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(A) Generalized arteriosclerosis  
Cerebral arteriosclerosis  
Coronary insufficiency  
Arteriosclerotic heart disease  
(B) Diabetes mellitus & acidosis  
(C) Hypertensive cardiovascular diseaseINTERVAL BETWEEN  
ONSET AND DEATH

?

?

?

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Hypertensive cardiovascular disease

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 6-29, 1950 to 6-29, 1950, that I last saw the deceased alive on 6-29, 1950, and that death occurred at 3:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

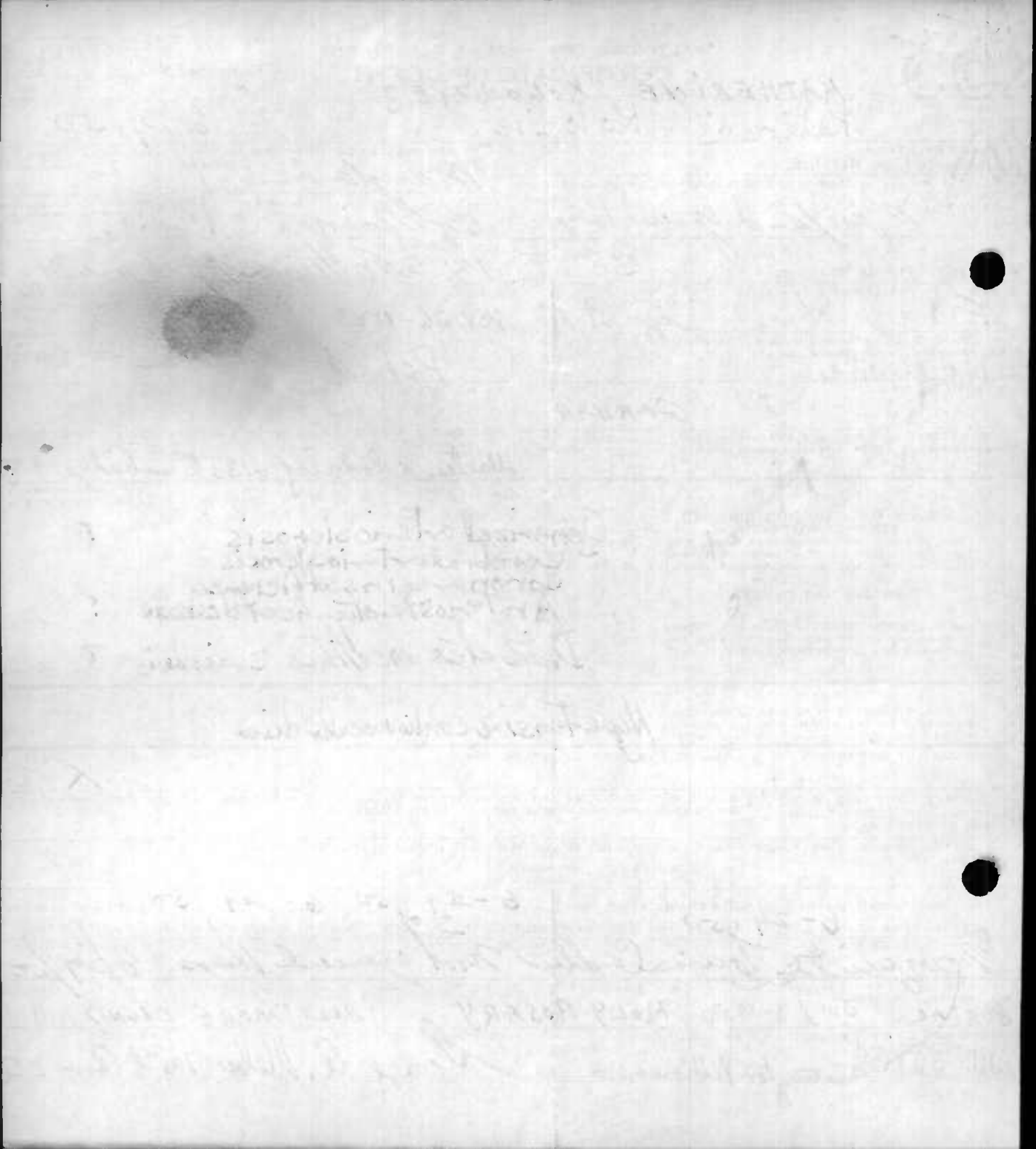
ADDRESS

JUN 30 1950

Huntington Williams, M.D.

George A. Weber 705 S. Ann St





H-543  
50 5766BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5766

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Franklin L Hamilton

2. DATE  
OF  
DEATH

6/28 5:0

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

1606 W. Cullom St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

1606 W. Cullom St  
Balto Md 14-02

D. STREET ADDRESS (If rural, give location)

1606 W. Cullom St

C. Length of stay in Baltimore

Life

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years;  
last birthday)10. Under 1 Year  
Months: Days  
11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

13. FATHER'S NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A) PULMONARY TUBERCULOSIS  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/18/50, to 6/28/50, that I last saw the  
deceased alive on 6/27, 1950, and that death occurred at 5:30 pm, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

UN 30-1950

Kington Williams, M.D.

308V9

13B



N-400  
LC 139671 50 5767  
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5767  
Registered No.

|   |                                  |  |  |  |   |
|---|----------------------------------|--|--|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>William Perry Neil</b>  |                                  |  | 2. DATE OF DEATH<br><b>June 27, 1950</b>   |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |  |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTE <b>Baltimore City Hospitals</b><br><b>4940 Eastern Avenue</b> |                                  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>16-01</b>                  |  |   |
| c. Length of stay in Baltimore <b>30 Yrs.</b><br>Yrs. Mos. Days   |                                  |  | D. STREET ADDRESS (If rural, give location)<br><b>1044 Stockton Street</b>   |  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Negro</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Single</b> | 8. DATE OF BIRTH<br><b>May 3, 1869</b>   | 9. AGE (In years last birthday)<br><b>81</b> | If Under 1 Year Months: Days<br>If Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY                                | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?                                  |
| 13. FATHER'S NAME<br><b>Thomas Neil</b>   |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>Anna Busce</b>  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.  | 17. INFORMANT <b>Baltimore City Hospitals</b><br><b>Records* 4940 Eastern Avenue</b>   |  |   |

|   |  |                                  |
|---|--|----------------------------------|
| 18. <b>4200</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Acute Pulmonary Edema</b><br>(A) DUE TO<br><b>Arteriosclerotic heart disease</b><br>(B) DUE TO<br>(C) DUE TO |  | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |                                  |

|  |   |  |   |   |
|--|---|--|---|---|
| 19A. DATE OF OPERATION <b>✓</b>  |   | 19B. MAJOR FINDINGS OF OPERATION   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |   |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |   |
| 22. I hereby certify that I attended the deceased from <b>March 31, 1950</b> to <b>June 27, 1950</b> , that I last saw the deceased alive on <b>June 27, 1950</b> , and that death occurred at <b>10:45 PM</b> , from the causes and on the date stated above. |   |  |   |   |
| 23A. SIGNATURE <b>Ch. Rogers</b><br>M. O.  |   | 23B. ADDRESS <b>4940 Eastern Avenue</b>                                  |   | 23C. DATE SIGNED <b>June 28, 1950</b>   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  | 24B. DATE <b>July 1, 1950</b>   | 24C. NAME OF CEMETERY OR CREMATORY <b>W. B. Miller Memorial Park</b>     | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Co.</b> |   |
| DATE RECEIVED BY LOCAL REGISTRAR   | REGISTRAR'S SIGNATURE   | 25. FUNERAL DIRECTOR   |   | ADDRESS   |
| <b>Funeral Home, 1631 N. W. 11 Ave.</b>  |   |  |   |   |

30, 1950

937

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

Count 141110 White Pine, California  
Walter F. Brown, Jr. 1911

362

50 5768

RE-A-137105

BIRTH NO.

50 5768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

50 5768

I. NAME OF DECEASED  
(Type or Print)

Sarah Weathers

2. DATE OF DEATH

June 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

Balto. City

Baltimore City Hospital

4940 Eastern Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

5. SEX

Female

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Feb. 6 1878

9. AGE (In years last birthday)

72

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Godfrey

14. MOTHER'S MAIDEN NAME

Betty

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Baltimore City Hospital

Records: 4940 Eastern Avenue

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction

DUE TO

II

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Cardiovascular Disease

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 5, 1950, to June 28, 1950, that I last saw the deceased alive on June 28, 1950, and that death occurred at 7:15 A, from the causes and on the date stated above.

23A. SIGNATURE

W. Hogan

M. D.

4940 Eastern Avenue

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

June 28, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7/1/1950

24C. NAME OF CEMETERY OR CREMATORY

Mt Calvary Cem.

24D. LOCATION (City, town, or county) (State)

Brooklyn A.A.Co.Md

DATE RECEIVED BY LOCAL REGISTRAR

JUN 30 1950

REGISTRAR'S SIGNATURE

Wm. H. Williams, M.D.

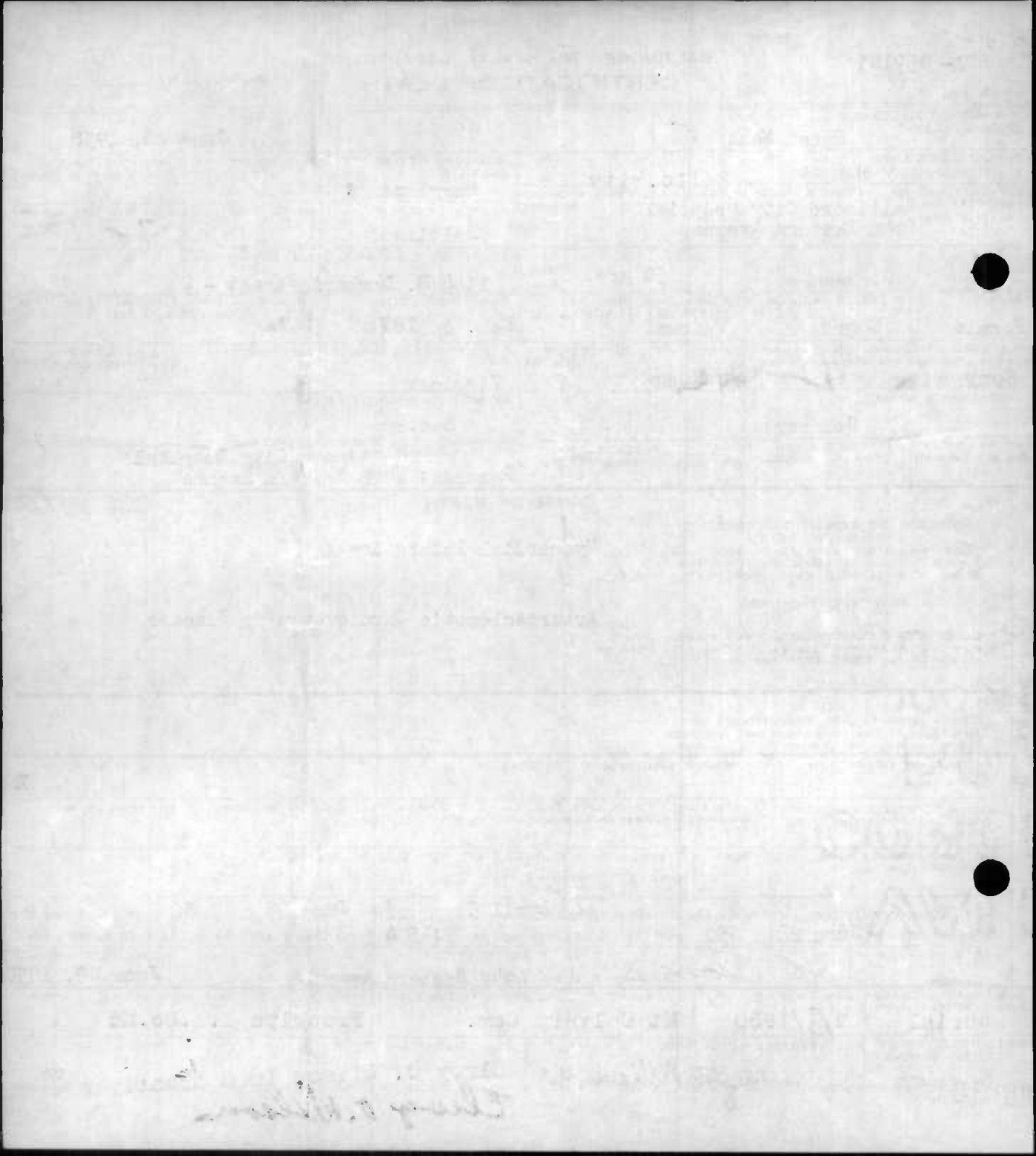
25. FUNERAL DIRECTOR

Elroy O. Wilson

1000 Brantly Ave

937





36 50 5769

50 5769

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

John Carter

2. DATE  
OF  
DEATH

June 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Balto. City

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Provident Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto. City

D. STREET ADDRESS (If rural, give location)

1019 Brantly Ave

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

8/30/1897

9. AGE (In years  
last birthday)

52

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Porter

10B. KIND OF BUSINESS OR  
INDUSTRY

May Co Dept. Store

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Carter

14. MOTHER'S MAIDEN NAME

Susan Pinkard

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

John Carter Jr 1205 Argyle Ave

18. 446 X I CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Renal insufficiency

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Nephrosclerosis

DUE TO

(C)

Ess. hypertension

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN  
ONSET AND DEATH

Undet.

Undet.

Undet.

19A. DATE OF OPERATION 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-20-50, 1950, to 6-27-1950, that I last saw the  
deceased alive on 6-27-1950, and that death occurred at 7:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

IN 301950

Washington Williams, M.D.

Elroy O. Wilson 1000 Brantly Ave

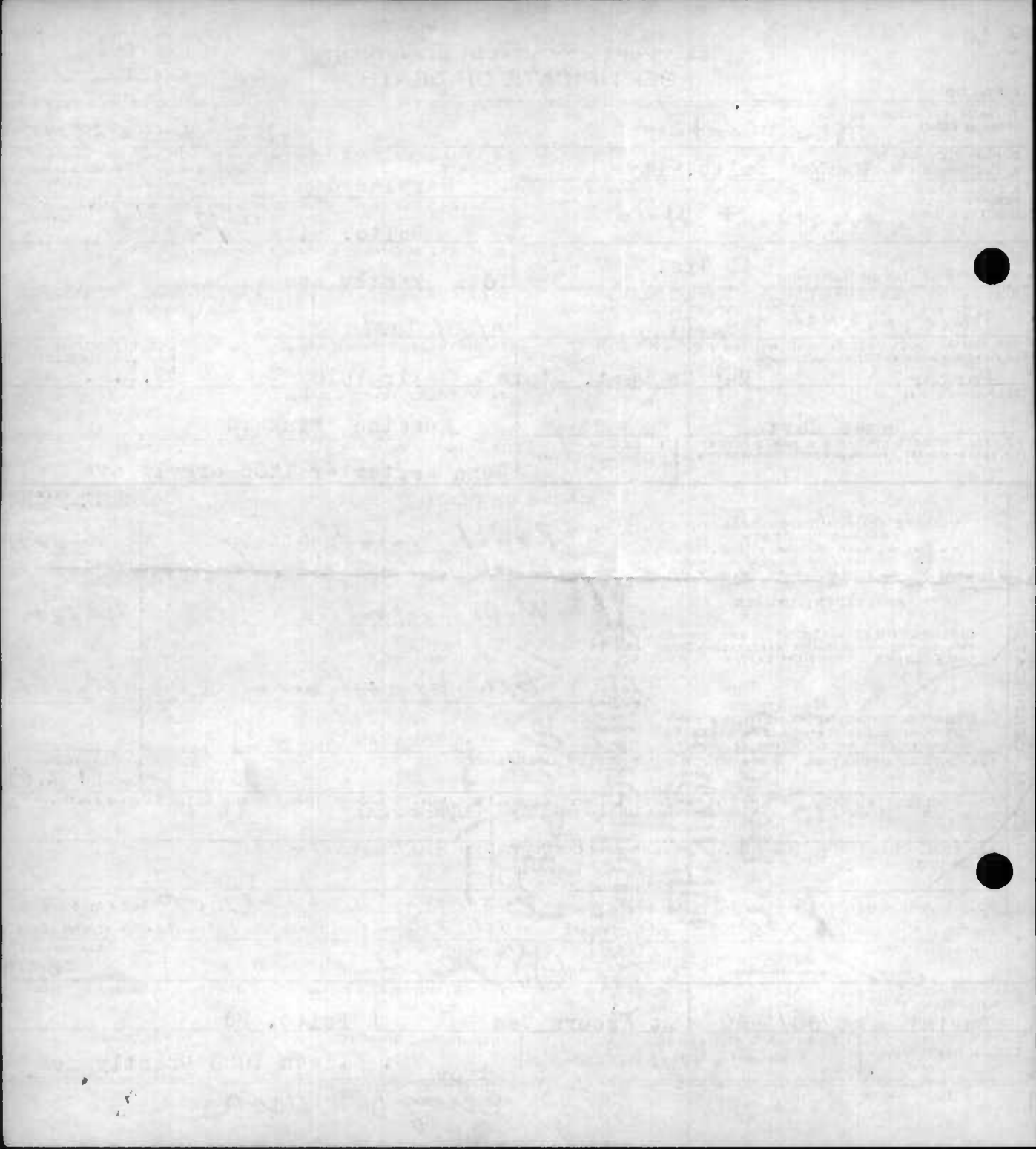
VS 150

75063

Elroy O. Wilson

131a

MEDICAL CERTIFICATION



4080 5770

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5770  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Rose Hill

2. DATE  
OF DEATH JUN 28 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Balto. City

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md

B. COUNTY

C. CITY OR TOWN (If outside corporate limits write RURAL and give township)

Baltimore 6-05

D. STREET ADDRESS (If rural, give location)

306 N. ANN ST

c. Length of stay in Baltimore

35 Yrs.

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Dec. 8, 1896

9. AGE (in years last birthday)

53

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Isle of White Virginia

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Quincy Briggs

14. MOTHER'S MAIDEN NAME

Unkown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 443 X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Hypertensive &amp; arteriosclerotic

DUE TO

(C) cardiovascular disease

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-28-1950 to 6-28-1950, that I last saw the deceased alive on 6-28-1950 and that death occurred at 9:05 m., from the causes and on the date stated above.

23A. SIGNATURE

William W. Winters

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

6-29-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

7/3/1950

24C. NAME OF CEMETERY OR CREMATORY

Arbutus Mem. Park

24D. LOCATION (City, town, or county)

Balto. Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William W. Winters, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Elroy O. Wilson 1000 Brantly Ave

Elroy O. Wilson

937

Rose Hill

Mr.

John D. Smith

John D. Smith

Cerebral primorphae

Hydrocephalus & arterio-sclerotic  
cardiovascular disease

P-54-20

William W. Dainton

160

50 5771

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5771  
Registered No.

BIRTH NO.

|   |                                    |  |                                     |
|---|------------------------------------|--|-------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>PERCY OFFER</b>   |                                    | 2. DATE OF DEATH<br><b>June 27, 1950</b>   |                                     |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>Balto. City</b>  |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY |                                     |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL <b>US Marine Hospital</b><br>INSTITUTION <b>Wyman Pk. Drive &amp; 31st St.</b> |                                    | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>6-04</b>           |                                     |
| C. Length of stay in Baltimore <b>Life</b> Yrs. Mos. Days   |                                    | D. STREET ADDRESS (If rural, give location)<br><b>212 N. Wolfe Street</b>  |                                     |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>colored</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Single</b>   | 8. DATE OF BIRTH<br><b>10/28/08</b> |
| 9. AGE (In years last birthday)<br><b>41</b>  |                                    | 10. Under 1 Year: Months Days; Under 24 Hours: Hours Min.  |                                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>   |                                    | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Baltimore Signal Depot</b>   |                                     |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                     |
| 13. FATHER'S NAME<br><b>Harry Offer</b>   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Pearl Wallace</b>   |                                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>Wre # 2</b>   |                                    | 16. SOCIAL SECURITY NO.<br><b>?</b>  |                                     |
| 17. INFORMANT<br><b>Records- US Marine Hospital, Balto, Md.</b>   |                                    | ADDRESS  |                                     |

|   |  |  |
|---|--|--|
| 18. <b>443 X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Hypertensive cardiovascular disease</b><br>(A) DUE TO <b>with</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Unknown</b><br><br><b>22 days</b> |
| ANTECEDENT CAUSES<br><b>Uremia</b><br>(B) DUE TO  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>(C)  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 19A. DATE OF OPERATION <b>0</b>   |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>June 5</b> , 1950, to <b>June 27</b> , 1950, that I last saw the deceased alive on <b>June 27</b> , 1950, and that death occurred at <b>9:20 P m.</b> , from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE<br><b>John L. Wilson, Medical Director M.D.</b>  |  | 23B. ADDRESS<br><b>US Marine Hospital, Balto, Md.</b>   |  | 23C. DATE SIGNED<br><b>6/28/50</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>7/3/1950</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Balto. Nat. Cem.</b>                       |  |
| 24D. LOCATION (City, town, or county)<br><b>Baltimore Md</b>  |  | 24E. STATE<br><b>Md</b>   |  |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 30 1950</b>  |  | REGISTRAR'S SIGNATURE<br><b>Washington Williams, M.D.</b>   |  | 25. FUNERAL DIRECTOR<br><b>Elroy O. Wilson 1000 Brantly Ave</b>                     |  |
| VS 150  |  | <b>98883 Elroy O. Wilson 93</b>   |  |   |  |



UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

|     |               |        |         |
|-----|---------------|--------|---------|
| No. | Name of Plant | Origin | Remarks |
| 1   | Cotton        | India  | Ginned  |
| 2   | Cotton        | India  | Ginned  |
| 3   | Cotton        | India  | Ginned  |
| 4   | Cotton        | India  | Ginned  |
| 5   | Cotton        | India  | Ginned  |
| 6   | Cotton        | India  | Ginned  |
| 7   | Cotton        | India  | Ginned  |
| 8   | Cotton        | India  | Ginned  |
| 9   | Cotton        | India  | Ginned  |
| 10  | Cotton        | India  | Ginned  |
| 11  | Cotton        | India  | Ginned  |
| 12  | Cotton        | India  | Ginned  |
| 13  | Cotton        | India  | Ginned  |
| 14  | Cotton        | India  | Ginned  |
| 15  | Cotton        | India  | Ginned  |
| 16  | Cotton        | India  | Ginned  |
| 17  | Cotton        | India  | Ginned  |
| 18  | Cotton        | India  | Ginned  |
| 19  | Cotton        | India  | Ginned  |
| 20  | Cotton        | India  | Ginned  |
| 21  | Cotton        | India  | Ginned  |
| 22  | Cotton        | India  | Ginned  |
| 23  | Cotton        | India  | Ginned  |
| 24  | Cotton        | India  | Ginned  |
| 25  | Cotton        | India  | Ginned  |

460 50 5772  
REA-133647BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

|   |                                  |  |   |  |  |
|---|----------------------------------|--|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Katie Mueller</b>   |                                  |  | 2. DATE OF DEATH<br><b>June 28, 1950</b>  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY _____ |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>Baltimore City Hospitals</b><br><b>4940 Eastern Avenue</b> |                                  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>19-02</b>                     |  |  |
| C. Length of stay in Baltimore <b>L ife</b> Yrs. _____ Mos. _____ Days _____  |                                  |  | D. STREET ADDRESS (If rural, give location)<br><b>129 N. Fulton Avenue</b>  |  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Single</b> | 8. DATE OF BIRTH<br><b>April 3, 1878</b>  |  | 9. AGE (In years last birthday)<br><b>72</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY                                |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                 |  |
| 13. FATHER'S NAME<br><b>Deceased</b>  |                                  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>(D)</b>  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br><b>Baltimore City Hospital Records: 4940 Eastern Avenue</b> |  |

|   |  |                                  |
|---|--|----------------------------------|
| 18. <b>151X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Carcinoma of the Stomach</b><br>DUE TO<br>(A) _____<br>ANTECEDENT CAUSES<br>(B) _____<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(C) _____<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  | INTERVAL BETWEEN ONSET AND DEATH |
|---|--|----------------------------------|

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 19A. DATE OF OPERATION <b>✓</b>   |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>11-21</b> , 19 <b>49</b> , to <b>6-28</b> , 19 <b>50</b> that I last saw the deceased alive on <b>6-28</b> , 19 <b>50</b> , and that death occurred at <b>6:15P</b> m., from the causes and on the date stated above. |  |  |  |   |  |
| 23A. SIGNATURE<br><i>H. Cohen</i>   |  | 23B. ADDRESS<br><b>4940 Eastern Avenue</b>   |  | 23C. DATE SIGNED<br><b>June 29, 1950</b>  |  |

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b> |  | 24B. DATE<br><b>7-1-50</b>                            |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cem</b>         |  | 24D. LOCATION (City, town, or county) (State)<br><b>Belair - Baltimore Md</b> |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 30 1950</b>     |  | REGISTRAR'S SIGNATURE<br><i>Wm. J. Williams, M.D.</i> |  | 25. FUNERAL DIRECTOR<br><b>Thos. J. Kennedy - Inc. 1600 HANCOCK ST</b> |  | ADDRESS   |  |

7-1-75 Mrs. J. Robinson, Co. 1  
The T. Kennedy - Inc. 1000 Main St.  
Baltimore, Md. 21201

612

50 5773

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5773  
Registered No.

|  |                                  |   |  |  |   |
|--|----------------------------------|---|--|--|---|
| BIRTH NO.  |                                  | 1. NAME OF DECEASED<br>(Type or Print) <b>MR. WILLIAM H. KREBS</b>  |  | 2. DATE OF DEATH<br><b>6-29-1950</b>         |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Anne Arundel</b> |  |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>ST. Agnes Hospital</b>   |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Woodland Beach-Pasadena</b>                                  |  |  |   |
| C. Length of stay in Baltimore   |                                  | D. STREET ADDRESS (If rural, give location)<br><b>5200</b>  |  |  |   |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>married</b>   | 8. DATE OF BIRTH<br><b>Jan. - 5 - 1903</b> | 9. AGE (In years last birthday)<br><b>47</b> | 10. Under 1 Year<br>Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Tavern Owner</b> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)    |   |
| 13. FATHER'S NAME<br><b>Howard Krebs</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mathilda Miller</b>  |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)                                |                                  | 16. SOCIAL SECURITY NO.<br><b>81X-140-487</b>   |  | 17. INFORMANT ADDRESS                        |   |

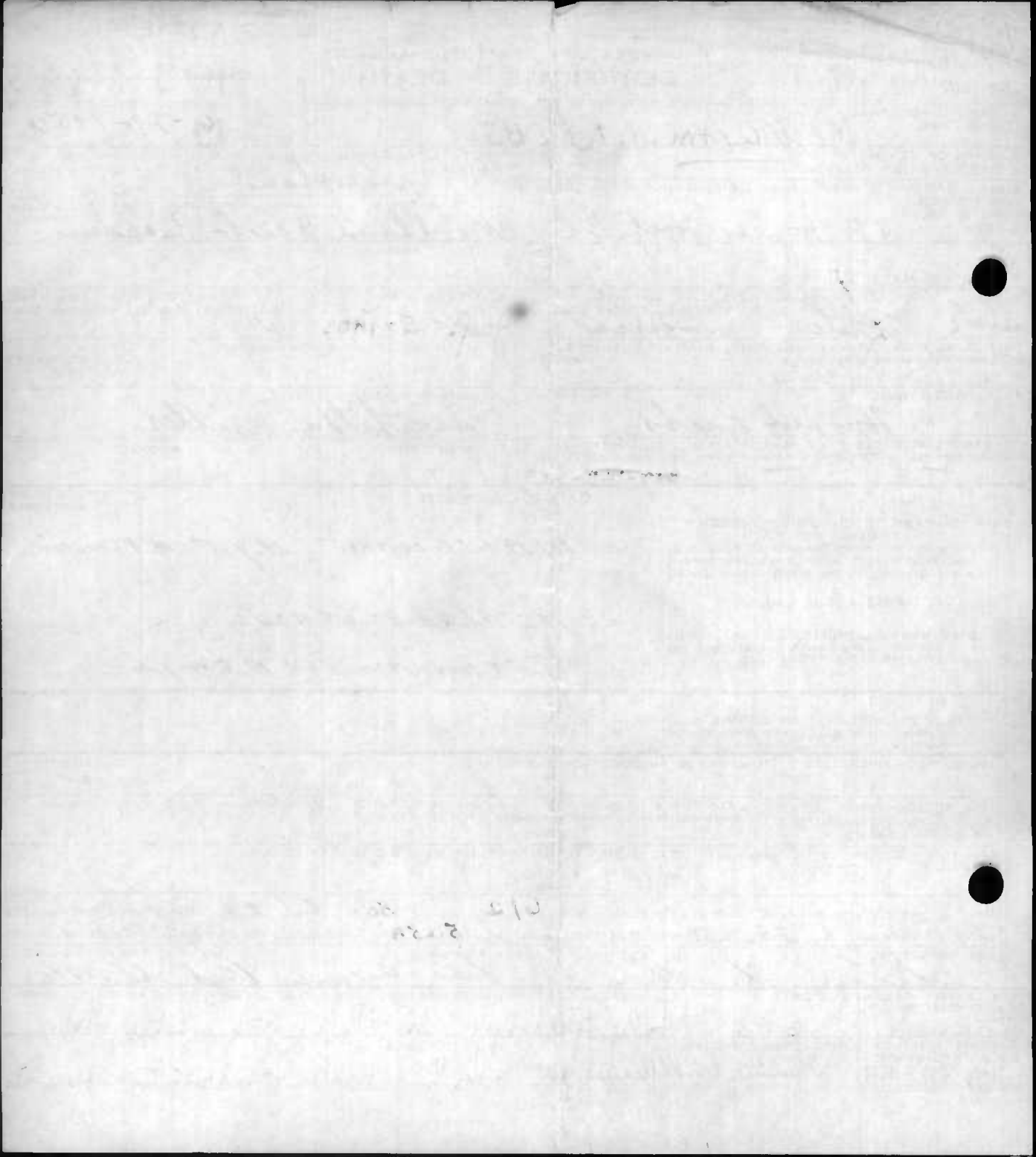
|   |                                  |
|---|----------------------------------|
| 18. <b>446X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b> | INTERVAL BETWEEN ONSET AND DEATH |
| (A) <b>MALIGNANT HYPERTENSION</b><br>DUE TO   |                                  |
| (B) <b>NEPHROSCLEROSIS</b><br>DUE TO  |                                  |
| (C) <b>TERMINAL UREMIA</b>  |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                                  |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 19A. DATE OF OPERATION<br><b>7</b>  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)               |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <b>6/2</b> , 1950, to <b>6/29</b> , 1950, that I last saw the deceased alive on <b>6/29</b> , 1950, and that death occurred at <b>5:45 AM.</b> , from the causes and on the date stated above. |  |   |  |  |  |
| 23A. SIGNATURE<br><b>John H. Shaw</b>   |  | 23B. ADDRESS<br><b>10. Agnes Ave.</b>   |  | 23C. DATE SIGNED<br><b>6/29/50</b>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   |  | 24B. DATE<br><b>7-3-50</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cem Belair Rd Baltimore Md.</b> |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 30 1950</b>  |  | REGISTRAR'S SIGNATURE<br><b>Wilmington Williams, M.D.</b>   |  | 25. FUNERAL DIRECTOR<br><b>John C. Muller Inc. 2425 E. Olney St</b>                    |  |

15671

131a

MEDICAL CERTIFICATION



230  
50 5774Hucht  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5774  
Registered No.

BIRTH NO.

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>John J. Hucht</i>   |  |  | 2. DATE OF DEATH <i>6-28-1950</i>   |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>1317 N. Port St</i>  |  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission):<br>A. STATE <i>MD</i><br>B. COUNTY |  |  |
| 5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)<br><i>John J. Hucht</i> |  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore</i>                          |  |  |
| 6. PLACE OF BIRTH (If not in hospital or institution, give street address or location)<br><i>00</i>                   |  |  | D. STREET ADDRESS (If rural, give location)<br><i>1317 N. Port St</i>   |  |  |
| 7. SEX<br><i>Male</i>   |  |  | 8. DATE OF BIRTH<br><i>April 4, 1894</i>  |  |  |
| 9. COLOR OR RACE<br><i>White</i>  |  |  | 10. AGE (in years, last birthday)<br><i>56</i>  |  |  |
| 11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Widowed</i>  |  |  | 12. If Under 1 Year: Months: Days<br>If Under 24 Hours: Hours: Min.   |  |  |
| 13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Retired</i>          |  |  | 14. BIRTHPLACE (State or foreign country)<br><i>Baltimore Md.</i>   |  |  |
| 15. KIND OF BUSINESS OR INDUSTRY<br><i>Retired</i>  |  |  | 16. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>   |  |  |
| 17. FATHER'S NAME<br><i>Theodore Hucht</i>  |  |  | 18. MOTHER'S MAIDEN NAME<br><i>Mary A. Imwald</i>   |  |  |
| 19. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><i>No</i>  |  |  | 20. SOCIAL SECURITY NO.<br><i>1317 N. Port St</i>   |  |  |
| 21. INFORMANT<br><i>Mary A. Hucht</i>   |  |  | 22. ADDRESS<br><i>1317 N. Port St</i>   |  |  |

MEDICAL CERTIFICATION

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| 18. <i>422.1</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Cerebral Thrombosis</i>            |  |  | CAUSE OF DEATH<br>(A) <i>Cerebral Thrombosis</i><br>DUE TO  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>4 weeks</i>                       |  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><i>Arteriosclerosis Cardio-vascular disease</i>   |  |  | (B) <i>Arteriosclerosis Cardio-vascular disease</i><br>DUE TO   |  |  | ?  |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |  | (C)   |  |  |  |  |  |
| 19A. DATE OF OPERATION<br><i>0</i>  |  |  | 19B. MAJOR FINDINGS OF OPERATION  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  |  | 21F. HOW DID INJURY OCCUR?   |  |  |
| 22. I hereby certify that I attended the deceased from <i>Feb. 22, 1950</i> to <i>June 28, 1950</i> , that I last saw the deceased alive on <i>June 28, 1950</i> , and that death occurred at <i>2:00</i> m., from the causes and on the date stated above. |  |  |   |  |  |  |  |  |
| 23A. SIGNATURE<br><i>Leon A. Kochman</i>  |  |  | 23B. ADDRESS<br><i>1037 N. Calver St</i>  |  |  | 23C. DATE SIGNED<br><i>6-29-50</i>                                       |  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  |  | 24B. DATE<br><i>7-1-1950</i>  |  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Holy Redeemer Cem</i>           |  |  |
| 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore Md</i>  |  |  | 24E. NAME OF FUNERAL DIRECTOR<br><i>John C. Miller Inc</i>  |  |  | 24F. ADDRESS<br><i>2435 E. Oliver St</i>                                 |  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUN 30 1950</i>  |  |  | REGISTRAR'S SIGNATURE<br><i>Wilmington Williams</i>   |  |  | 25. FUNERAL DIRECTOR<br><i>John C. Miller Inc</i>                        |  |  |
| VS 150  |  |  |   |  |  | 937  |  |  |



W. Leon Freeman  
1027 N. Belmont St.

# CERTIFICATE CORRECTED

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 50 5775

BIRTH NO. 5775 50-02651

|  |                                  |  |   |   |                               |
|--|----------------------------------|--|---|---|-------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <u>Linda PARKER</u>   |                                  |  | 2. DATE OF DEATH <u>June 29, 1950</u>   |   |                               |
| 3. PLACE OF DEATH:<br>A. <u>Baltimore City, Maryland</u> <u>Baltimore</u>  |                                  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>Maryland</u><br>B. COUNTY <u>Baltimore</u> |   |                               |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><u>Baltimore City Hospital</u> |                                  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><u>Baltimore</u> <u>26-08</u>                                   |   |                               |
| C. Length of stay in Baltimore <u>4 1/2</u> - Yrs. Mos. Days   |                                  |  | D. STREET ADDRESS (If rural, give location)<br><u>124 S. Conklin St.</u>  |   |                               |
| 5. SEX<br><u>FEMALE</u>  | 6. COLOR OR RACE<br><u>WHITE</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Single</u> | 8. DATE OF BIRTH<br><u>2-9-1950</u>   | 9. AGE (In years last birthday)<br><u>4 1/2</u> | 10. Under 1 Year Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>none</u>             |                                  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |   |                               |
| 10B. KIND OF BUSINESS OR INDUSTRY  |                                  |  | 12. CITIZEN OF WHAT COUNTRY?  |   |                               |
| 13. FATHER'S NAME<br><u>Charles Parker</u>   |                                  |  | 14. MOTHER'S MAIDEN NAME<br><u>Lillian L. Lamke</u>   |   |                               |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>-</u>   |                                  |  | 16. SOCIAL SECURITY NO.<br><u>-</u>   |   |                               |
| 17. INFORMANT<br><u>Mrs. Lillian L. Parker</u>   |                                  |  | ADDRESS <u>St. 124 S. Conklin</u>   |   |                               |

|   |  |                                  |
|---|--|----------------------------------|
| 18. <u>391.0</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, apsthenia, etc. It means the disease, injury or complication which caused death.)<br><u>Otitis media, acute, bilateral</u><br>DUE TO<br>(A) <u>Otitis media, acute, bilateral</u><br>(B) <u></u><br>(C) <u></u> |  | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A): STATING THE UNDERLYING CONDITION LAST.<br>(B) <u></u><br>(C) <u></u>   |  |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT.  |  |                                  |

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 19A. DATE OF OPERATION <u>7-1-50</u>  |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                             |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that I took charge of the remains described above, held an <u>Autopsy</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |  |  |  |   |  |
| 23A. SIGNATURE<br><u>R. S. Fisher</u>   |  | 23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> M.D. |  | 23C. DATE SIGNED<br><u>June 29, 1950</u>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 24B. DATE<br><u>7-1-50</u>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Oaklawn</u>                                |  |
| 24D. LOCATION (City, town, or county)<br><u>Baltimore</u>   |  | 24E. STATE<br><u>Md.</u>   |  | 24F. FUNERAL DIRECTOR<br><u>John A. Moran</u>                                       |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><u>JUN 30 1950</u>  |  | REGISTRAR'S SIGNATURE<br><u>Huntington Williams, M.D.</u>  |  | ADDRESS<br><u>3000 E. Baltimore St</u>  |  |

89a ✓

# MINISTRE DE LA SANTE CERTIFICATE OF DEATH

Province of Ontario

Registration No.

Sex

Age

Residence

Date

1-2-78

Deceased

1-2-78

1-2-78

1-2-78

CAUSE OF DEATH

1-2-78

1-2-78

1-2-78

1-2-78

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1-2-78

260  
5776BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5776

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mary Wacker

2. DATE  
OF  
DEATH

6-29-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Md B. COUNTYB. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

525 S. Curley Street

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore, Md. 1-02

C. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

525 S. Curley Street

5. SEX

F.

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Married

B. DATE OF BIRTH

6-11-91

9. AGE (In years last birthday) 59  
If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?  
USA

13. FATHER'S NAME

Michael Rachuba

14. MOTHER'S MAIDEN NAME

Mary ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
Frederick Wacker-525 S. Curley Street18. 443 X  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CAUSE OF DEATH  
Hypertensive Cardio-Vascular Disease - Chronic hypertension - Arteriosclerosis  
(A) DUE TO  
(B) DUE TO  
(C) DUE TO

INTERVAL BETWEEN ONSET AND DEATH

5 y.

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/31/1950 to 6/29/1950 that I last saw the deceased alive on 6/30/1950 and that death occurred at 8:45 P.M., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7-3-50

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn

24D. LOCATION (City, town, or county)

Baltimore Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Lilly &amp; Zeiler, Inc., 403 S. Wolfe Street



246  
50 5777

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5777  
Registered No.

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Charles Stewart McCleary</b>   |                                  | 2. DATE OF DEATH <b>6-29-50</b>   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>The Union Memorial Hospital</b>  |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 12-07</b>                      |   |
| C. Length of stay in Baltimore<br>Yrs. Mos. Days   |                                  | D. STREET ADDRESS (If rural, give location)<br><b>2738 Huntington Ave</b>   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Single</b>  | 8. DATE OF BIRTH<br><b>Oct. 16 1897</b> |
| 9. AGE (In years last birthday)<br><b>52</b>   |                                  | 10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.  |   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Roofers</b>  |                                  | 10B. KIND OF BUSINESS OR INDUSTRY   |   |
| 13. FATHER'S NAME<br><b>George S. McCleary</b>   |                                  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore Maryland</b>  |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Purcell</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>220-01-4676</b>   |   |
| 17. INFORMANT<br><b>Nora E. Truhy</b>  |                                  | ADDRESS<br><b>2909 Miles Ave</b>  |   |
| 18. <b>158X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Coronary thrombosis</b><br>DUE TO<br><b>Coronary atherosclerosis</b><br>DUE TO<br><b>Diabetes mellitus</b> |                                  | CAUSE OF DEATH<br><b>Coronary thrombosis</b><br><b>Coronary atherosclerosis</b><br><b>Diabetes mellitus</b>                 |   |
| 19A. DATE OF OPERATION<br><b>6-29-50</b>   |                                  | 19B. MAJOR FINDINGS OF OPERATION  |   |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                  |   |   |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |                                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                    |   |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                                  |   |   |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   |                                  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                      |   |
| 21F. HOW DID INJURY OCCUR?   |                                  |   |   |
| 22. I hereby certify that I attended the deceased from <b>June 25, 1950</b> , to <b>June 29, 1950</b> , that I last saw the deceased alive on <b>June 29, 1950</b> , and that death occurred at <b>10:00 a.m.</b> , from the cause and on the date stated above.   |                                  |   |   |
| 23A. SIGNATURE<br><b>Frank L. Williams, M.D.</b>   |                                  | 23B. ADDRESS<br><b>Union Memorial Hosp</b>  |   |
| 23C. DATE SIGNED<br><b>6-29-50</b>   |                                  |   |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 24B. DATE<br><b>6/30/50</b>   |   |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>Greenwood</b>   |                                  | 24D. LOCATION (City, town, or county) (State)<br><b>Cockeville Tenn</b>   |   |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 30 1950</b>   |                                  | REGISTRAR'S SIGNATURE<br><b>Frank L. Williams, M.D.</b>   |   |
| 25. FUNERAL DIRECTOR<br><b>W. H. Moore</b>   |                                  | ADDRESS<br><b>1217 9th Ave S</b>  |   |

MEDICAL CERTIFICATION

350V9

46H



UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

PLANT INDUSTRY REPORT NO. 1000  
PLANT INDUSTRY REPORT NO. 1000

PLANT INDUSTRY REPORT NO. 1000  
PLANT INDUSTRY REPORT NO. 1000

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PLANT INDUSTRY REPORT NO. 1000

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50 5778

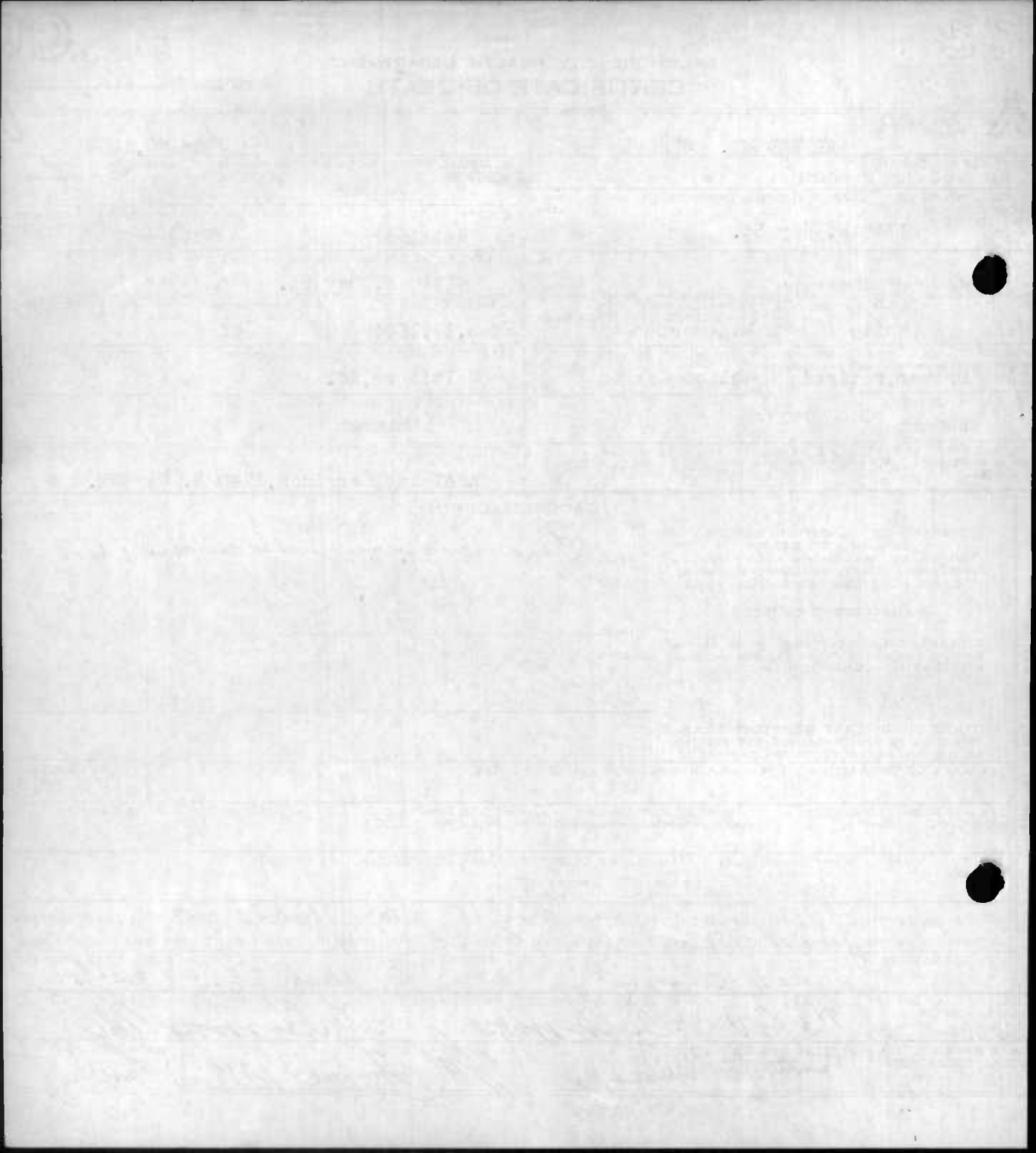
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5778

|  |                                  |   |   |  |   |
|--|----------------------------------|---|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>ALFRED R. SPROUL</b>   |                                  |   | 2. DATE OF DEATH <b>June 30, 1950</b>   |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>Baltimore</b> |  |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>1740 N. Gay St.</b>             |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>  |  |   |
| C. Length of stay in Baltimore<br>Yrs.<br>Mos.<br>Days   |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>1740 N. Gay St.</b>   |  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widower</b> | 8. DATE OF BIRTH<br><b>Feb. 17, 1884</b>  | 9. AGE (In years last birthday)<br><b>66</b> | If Under 1 Year Months: Days<br>If Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Taxi Driver, retired</b> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Yellow Cab Co</b>         | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?                                  |
| 13. FATHER'S NAME<br><b>Unknown</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)<br><b>No</b>                            |                                  | 16. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS<br><b>Adelaide Garrison, 1740 N. Gay St.</b>  |  |   |

|  |  |   |
|--|--|---|
| 18. <b>002X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Pulmonary Tuberculosis 1 yr.</b> |  | CAUSE OF DEATH<br>(A) <b>Pulmonary Tuberculosis 1 yr.</b><br>DUE TO |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  | (B)<br>DUE TO   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  | (C)<br>DUE TO   |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 19A. DATE OF OPERATION <b>0</b>   |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br><b>INJURY</b>  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <b>May 15, 1950</b> , to <b>June 30, 1950</b> , that I last saw the deceased alive on <b>June 28, 1950</b> , and that death occurred at <b>5 A</b> m., from the causes and on the date stated above. |  |   |  |  |  |
| 23A. SIGNATURE<br><b>Jacob Fisher</b>   |  | 23B. ADDRESS<br><b>1823 N. West St.</b>   |  | 23C. DATE SIGNED<br><b>6/30/50</b>                                       |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>  |  | 24B. DATE<br><b>7/3/50</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore</b>                   |  |
| 24D. LOCATION (City, town, or county)<br><b>Baltimore</b>   |  | 24E. LOCATION (City, town, or county)<br><b>Baltimore</b>   |  | 24F. LOCATION (City, town, or county)<br><b>Baltimore</b>                |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUN 30 1950</b>  |  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b>   |  | 25. FUNERAL DIRECTOR<br><b>1217 St Paul St</b>                           |  |



452  
5779

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5779

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) **MR HOWARD FRANKLIN WILLIAMS** 2. DATE OF DEATH **6-30-50**

3. PLACE OF DEATH: A. Baltimore City, Maryland 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

B. FULL NAME OF HOSPITAL OR INSTITUTION **BON SECOURS HOSPT.** C. CITY OR TOWN **MARYLAND** (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location) **124 S MADEIRA ST.**

5. SEX **M** 6. COLOR OR RACE **W** 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **M** 8. DATE OF BIRTH **7-6-12** 9. AGE (In years last birthday) **37** 10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Conductor** 10B. KIND OF BUSINESS OR INDUSTRY **Conductor Railroad** 11. BIRTHPLACE (State or foreign country) **Md.** 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME **Walter W Williams** 14. MOTHER'S MAIDEN NAME **Ann Hoffocher**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) **No** (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. **705-12-4365** 17. INFORMANT **Eva L Williams** ADDRESS **124 S Madeira St**

18. **592X** CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Uremia & Bronchitis** DUE TO

ANTECEDENT CAUSES (B) **Ch. - Generalized** DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) **Essential Hypertension**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **0** 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY 21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **6-22**, 19**50**, to **6-30**, 19**50**, that I last saw the deceased alive on **6-30**, 19**50**, and that death occurred at **10:45** A. M., from the causes and on the date stated above.

23A. SIGNATURE **Geo. D Solomon** M. D. 23B. ADDRESS **Bon Secours Hosp.** 23C. DATE SIGNED **6-30-50**

24A. BURIAL, CREMATION, REMOVAL (Specify) **buried** 24B. DATE **7/3/50** 24C. NAME OF CEMETERY OR CREMATORY **Baltimore** 24D. LOCATION (City, town, or county) (State) **Baltimore Md**

DATE RECEIVED BY LOCAL REGISTRAR **JUN 30 1950** REGISTRAR'S SIGNATURE **Washington Williams, M.D.** 25. FUNERAL DIRECTOR **W. C. ...** ADDRESS **1219 S ...**

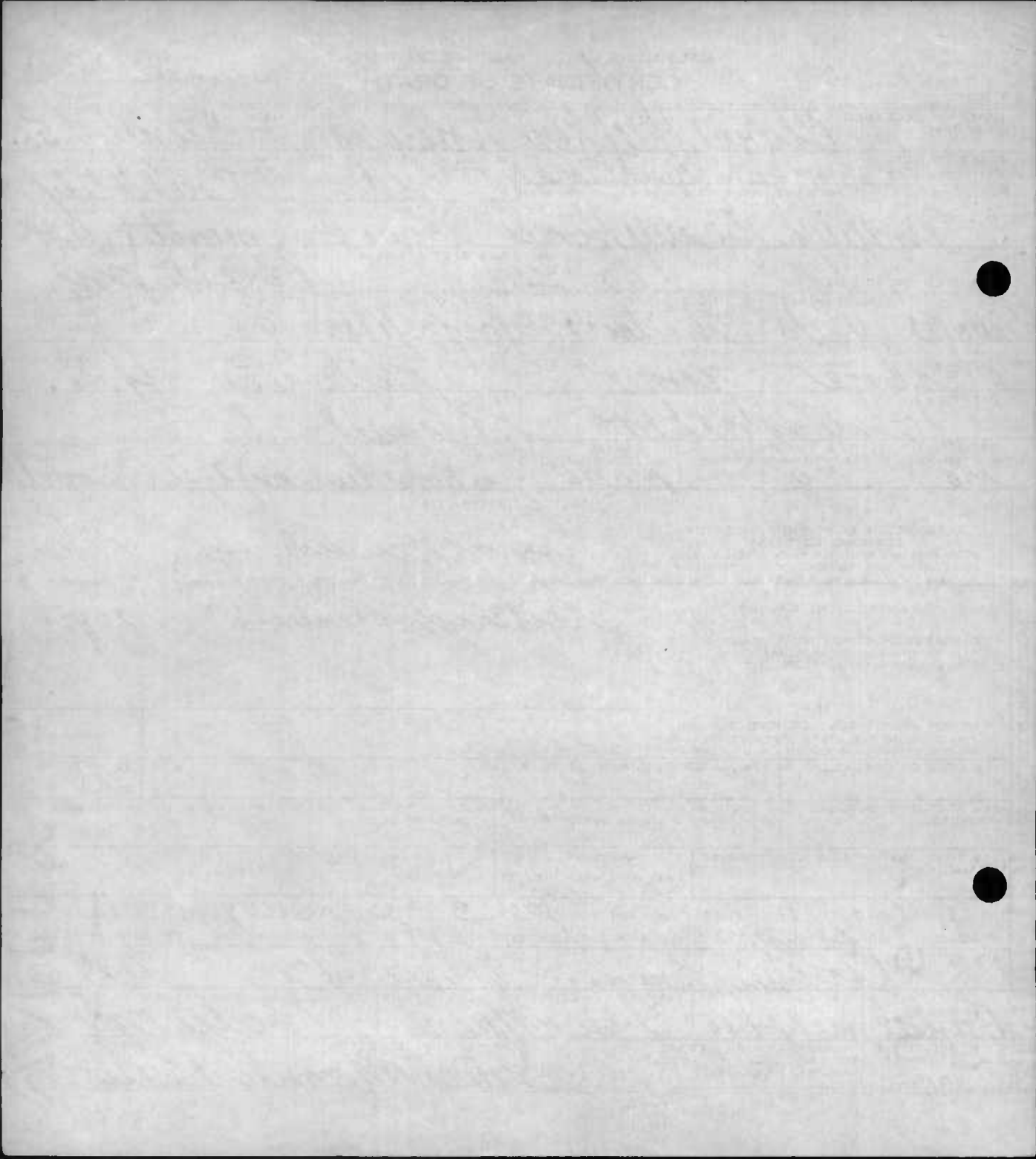
MEDICAL CERTIFICATION

BALTIMORE HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

|                  |  |                |  |                   |  |                   |  |               |  |                  |  |                   |  |                     |  |                 |  |                        |  |                        |  |
|------------------|--|----------------|--|-------------------|--|-------------------|--|---------------|--|------------------|--|-------------------|--|---------------------|--|-----------------|--|------------------------|--|------------------------|--|
| Name of Deceased |  | Age            |  | Sex               |  | Race              |  | Date of Death |  | Time of Death    |  | Place of Death    |  | Cause of Death      |  | Manner of Death |  | Signature of Physician |  | Signature of Registrar |  |
| John Doe         |  | 45             |  | Male              |  | White             |  | 1912          |  | 10:30 AM         |  | Home              |  | Heart Disease       |  | Natural         |  | J. Smith               |  | A. Jones               |  |
| Occupation       |  | Residence      |  | Marital Status    |  | Education         |  | Religion      |  | Previous Illness |  | Previous Injuries |  | Previous Operations |  | Previous Habits |  | Previous Occupations   |  | Previous Residences    |  |
| Teacher          |  | 1234 Main St   |  | Married           |  | High School       |  | Catholic      |  | None             |  | None              |  | None                |  | None            |  | None                   |  | None                   |  |
| Date of Birth    |  | Place of Birth |  | Date of Admission |  | Date of Discharge |  | Date of Death |  | Time of Death    |  | Place of Death    |  | Cause of Death      |  | Manner of Death |  | Signature of Physician |  | Signature of Registrar |  |
| 1867             |  | Maryland       |  | 1911              |  | 1912              |  | 1912          |  | 10:30 AM         |  | Home              |  | Heart Disease       |  | Natural         |  | J. Smith               |  | A. Jones               |  |







600

MUIR

50 5781

## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mrs. Mary Ellen Muir

2. DATE  
OF  
DEATH

6/28/50.

3. PLACE OF DEATH

a. Baltimore City, Maryland

b. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Church Home + Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto. 18 9-07

D. STREET ADDRESS (If rural, give location)

1554 Carswell St.

c. Length of stay in Baltimore

64

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

W.

10a. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10b. KIND OF BUSINESS OR  
INDUSTRY

Housewife

11. BIRTHPLACE (State or foreign country)

Balto., Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA.

13. FATHER'S NAME

Wm. E. Majors

14. MOTHER'S MAIDEN NAME

Lizzie Lee Ward

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mrs. Hazel Clarke

ADDRESS

Same

18. 585 X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Empyema of gallbladder, 15 days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Acute suppurative cholangitis 5 days

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Acute pancreatitis weeks

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21a. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21b. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21d. TIME (Month) (Day) (Year) (Hour)  
INJURY

21e. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/18, 1950, to 6/28, 1950, that I last saw the deceased alive on 6/28, 1950, and that death occurred at 12:45 p.m., from the causes and on the date stated above.

23a. SIGNATURE

M. D.

23b. ADDRESS

23c. DATE SIGNED

24a. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUN 30 1950

Winnington Williams, M.D.

Lassahn Funeral Home, 7401 Belair Rd.

128

MEDICAL CERTIFICATION

RECEIVED  
JAN 10 1964

46 3 copies  
50 5782

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5782  
Registered No.

|   |                       |   |                              |   |  |
|---|-----------------------|---|------------------------------|---|--|
| BIRTH NO.   |                       | 1. NAME OF DECEASED<br>(Type or Print) Benjamin Geisler   |                              | 2. DATE OF DEATH<br>6/28/50                           |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                       | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland<br>B. COUNTY |                              |   |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>40 St. Agnes Hospital  |                       | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 20-03                         |                              |   |  |
| C. Length of stay in Baltimore Born Here  |                       | D. STREET ADDRESS (If rural, give location)<br>105 Payson St.   |                              |   |  |
| 5. SEX<br>M   | 6. COLOR OR RACE<br>W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Single   | 8. DATE OF BIRTH<br>11/25/03 | 9. AGE (In years last birthday)<br>46                 | 10. Under 1 Year<br>Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>City laborer |                       | 10B. KIND OF BUSINESS OR INDUSTRY<br>Baltimore City   |                              | 11. BIRTHPLACE (State or foreign country)<br>Maryland |  |
| 12. CITIZEN OF WHAT COUNTRY?<br>USA   |                       | 13. FATHER'S NAME<br>Louis Geisler  |                              |   |  |
| 14. MOTHER'S MAIDEN NAME<br>Anna M. Sturm   |                       | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO          |                              |   |  |
| 16. SOCIAL SECURITY NO.   |                       | 17. INFORMANT<br>Marie-Rockel - Same  |                              |   |  |

|   |  |
|---|--|
| 18. 209.0<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>ACUTE LYMPHATIC LEUKEMIA<br>DUE TO<br>ANTECEDENT CAUSES<br>BRONCHOPNEUMONIA<br>DUE TO<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | CAUSE OF DEATH<br>INTERVAL BETWEEN ONSET AND DEATH |
|---|--|

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 19A. DATE OF OPERATION<br>2/1/50  |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from 6/26, 1950 to 6/28, 1950, that I last saw the deceased alive on 6/28, 1950, and that death occurred at 11:45 PM, from the causes and on the date stated above. |  |  |  |   |  |
| 23A. SIGNATURE<br>John B. Shaw M. O.  |  | 23B. ADDRESS<br>St. Agnes Hosp   |  | 23C. DATE SIGNED<br>6/28/50   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Buried   |  | 24B. DATE<br>July 1-50   |  | 24C. NAME OF CEMETERY OR CREMATORY<br>London Park Cem.                              |  |
| 24D. LOCATION (City, town, or county)<br>Baltimore  |  | 24E. LOCATION (State)<br>Md  |  | 24F. DATE RECEIVED BY LOCAL REGISTRAR<br>JUN 30 1950                                |  |
| 24G. REGISTRAR'S SIGNATURE<br>Wilmington Williams, M.D.   |  | 24H. FUNERAL DIRECTOR<br>F. B. Wipf & Son  |  | 24I. ADDRESS<br>1300 East Ave   |  |

98A98 74a

71

24

WATER RIGHTS - 13

WATER RIGHTS - 13

WATER RIGHTS - 13

WATER RIGHTS - 13

WATER RIGHTS - 13

WATER RIGHTS - 13

WATER RIGHTS - 13

WATER RIGHTS - 13

140  
50 5783BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5783  
Registered No.

BIRTH NO.

|   |                        |   |   |                                    |   |
|---|------------------------|---|---|------------------------------------|---|
| 1. NAME OF DECEASED<br>(Type or Print) Evelyn M. Neville  |                        |   | 2. DATE OF DEATH June 28, 1950  |                                    |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                        |   | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE Maryland<br>B. COUNTY |                                    |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital   |                        |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 12-02                         |                                    |   |
| C. Length of stay in Baltimore 5 years  |                        |   | D. STREET ADDRESS (If rural, give location)<br>3219 N. Calvert St., Apt. 2  |                                    |   |
| 5. SEX Female   | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Aug: 26 -1903  | 9. AGE (In years last birthday) 46 | 10. Under 1 Year Months: Days Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Credit Manager-Casltelburgs |                        |   | 11. BIRTHPLACE (State or foreign country) England   |                                    |   |
| 10B. KIND OF BUSINESS OR INDUSTRY   |                        |   | 12. CITIZEN OF WHAT COUNTRY? USA.   |                                    |   |
| 13. FATHER'S NAME Unknown   |                        |   | 14. MOTHER'S MAIDEN NAME Unknown  |                                    |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, oo or unknown) No   |                        |   | 16. SOCIAL SECURITY NO. 216-09-9488   |                                    |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) *****                                      |                        |   | 17. INFORMANT ADDRESS Jerome F. Neville- same   |                                    |   |

|   |  |                                  |
|---|--|----------------------------------|
| 18. 330X<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>Subarachnoid hemorrhage<br>DUE TO ruptured cerebral aneurysm<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | CAUSE OF DEATH<br>(A) Subarachnoid hemorrhage<br>DUE TO ruptured cerebral aneurysm<br>(B)<br>DUE TO<br>(C) | INTERVAL BETWEEN ONSET AND DEATH |
|---|--|----------------------------------|

|  |   |  |
|--|---|--|
| 19A. DATE OF OPERATION   | 19B. MAJOR FINDINGS OF OPERATION  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)         |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>  | 21F. HOW DID INJURY OCCUR?   |
| 22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |   |  |
| 23A. SIGNATURE Stanley A. Decker M.D.  | 23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/> | 23C. DATE SIGNED June 28, 1950   |

|  |                        |  |  |
|--|------------------------|--|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE July 1, 1950 | 24C. NAME OF CEMETERY OR CREMATORY New Cathedral | 24D. LOCATION (City, town, or county) (State) Baltimore Maryland |
| DATE RECEIVED BY LOCAL REGISTRAR                 | REGISTRAR'S SIGNATURE  | 25. FUNERAL DIRECTOR F. B. WIPPERT & SON* L1300  | ADDRESS Cutaw Pl 17  |

V.S. 151

JUN 30 1950 -12463 OF B. WipPERT &amp; Son 96 ✓



ALTHOUGH THE DEEDS OF DEATH  
CERTIFICATE OF DEATH

NAME OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF BURIAL

DATE OF BURIAL

PLACE OF BURIAL

NAME OF BURIAL

DATE OF BURIAL

PLACE OF BURIAL

NAME OF BURIAL

DATE OF BURIAL

PLACE OF BURIAL

260  
5784

## CERTIFICATE CORRECTED 7-11-50

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

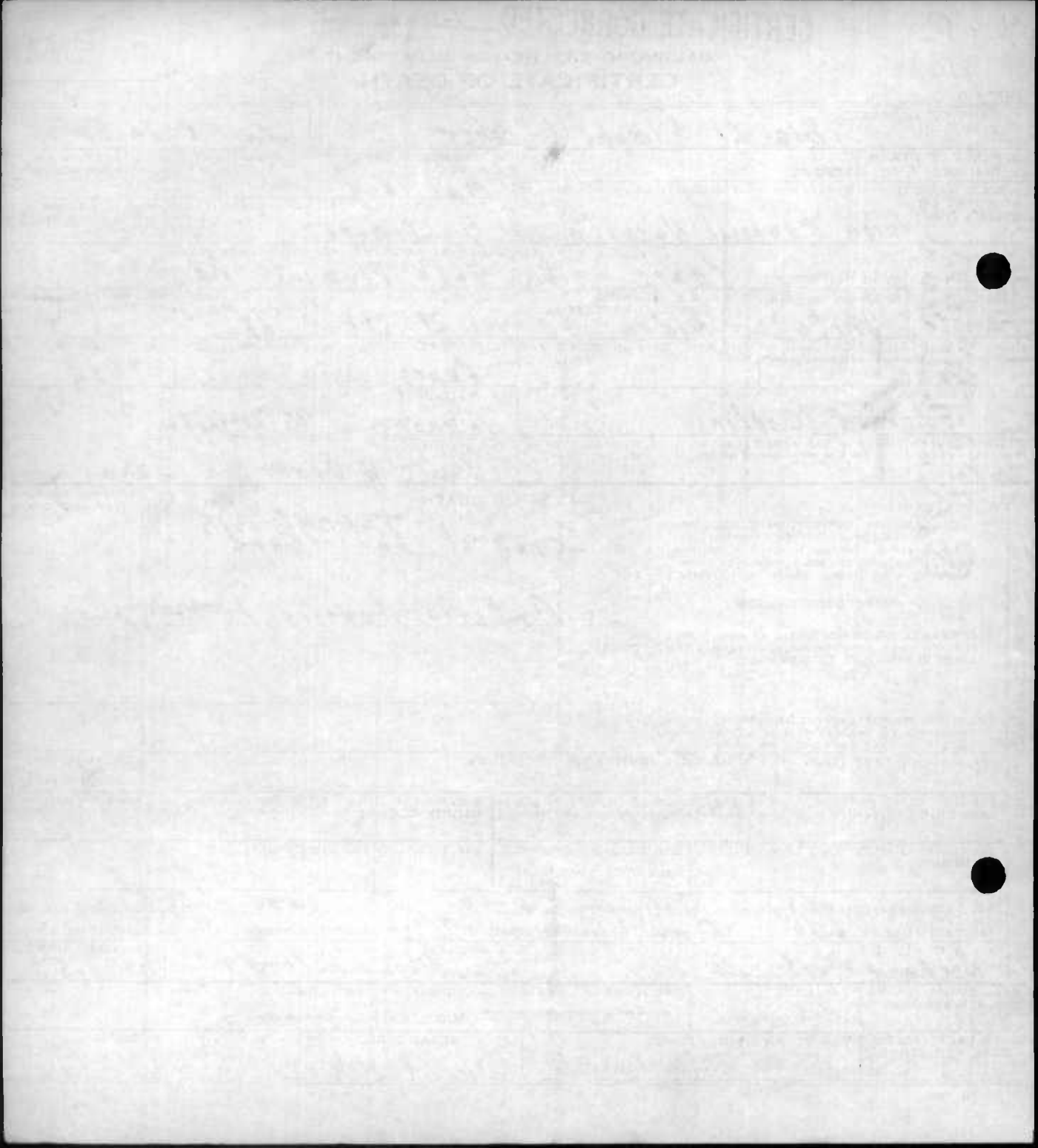
Registered No. 50 5784

BIRTH NO.

|  |                                  |   |   |  |   |
|--|----------------------------------|---|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Blanche Elisabeth Baker</i>                                      |                                  |   | 2. DATE OF DEATH<br><i>6-30-50</i>  |  |   |
| 3. PLACE OF DEATH:<br>a. Baltimore City, Maryland  |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <i>Maryland</i><br>b. COUNTY <i>Baltimore</i> |  |   |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>Union Memorial Hospital</i>                                  |                                  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 27-06</i>  |  |   |
| c. Length of stay in Baltimore<br><i>Years</i>   |                                  |   | d. STREET ADDRESS (If rural, give location)<br><i>5614 Plymouth Rd.</i>   |  |   |
| 5. SEX<br><i>Female</i>  | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Widow</i> | 8. DATE OF BIRTH<br><i>July 28, 1881</i>  | 9. AGE (In years last birthday)<br><i>68</i> | 10. Under 1 Year<br>Months: Days: Hours: Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>None</i> |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |  |   |
| 13. FATHER'S NAME<br><i>Edward Collins</i>   |                                  |   | 11. BIRTHPLACE (State or foreign country)<br><i>Pennsylvania</i>  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><i>Unknown</i>                        |                                  |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  |   |
| 16. SOCIAL SECURITY NO.  |                                  |   | 14. MOTHER'S/MAIDEN NAME<br><i>Unknown - Witherington?</i>  |  |   |
| 17. INFORMANT<br><i>James H Baker</i>  |                                  |   | ADDRESS<br><i>Same</i>  |  |   |

|  |   |                                  |
|--|---|----------------------------------|
| 18. <i>332 X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Cerebral THROMBOSIS</i> | CAUSE OF DEATH<br>(A) <i>Cerebral THROMBOSIS</i><br>DUE TO<br>(B) <i>Arteriosclerosis, Generalized</i><br>DUE TO<br>(C) | INTERVAL BETWEEN ONSET AND DEATH |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |   |                                  |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 19a. DATE OF OPERATION <i>7/3/50</i>   |  | 19b. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21d. TIME (Month) (Day) (Year) (Hour) INJURY   |  | 21e. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <i>6-10</i> , 19 <i>50</i> , to <i>6-30</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>6-30</i> , 19 <i>50</i> , and that death occurred at <i>2 1/2</i> m., from the causes and on the date stated above. |  |   |  |   |  |
| 23a. SIGNATURE<br><i>Richard R. Beach</i>  |  | 23b. ADDRESS<br><i>Union Memorial Hosp.</i>   |  | 23c. DATE SIGNED<br><i>6-30-50</i>  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  | 24b. DATE<br><i>7/3/50</i>  |  | 24c. NAME OF CEMETERY OR CREMATORY<br><i>Woodlawn</i>                               |  |
| 24d. LOCATION (City, town, or county) (State)<br><i>Farmville Md</i>   |  | 25. FUNERAL DIRECTOR<br><i>William C. Cook</i>  |  | ADDRESS<br><i>1314 S. Paul St</i>   |  |



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

50 5785

|   |                             |  |                            |
|---|-----------------------------|--|----------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Lillian Hickman</b>   |                             | 2. DATE OF DEATH<br><b>June 27 1950</b>  |                            |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Unknown</b> B. COUNTY _____ |                            |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION <b>Good Samaritan Hospital</b>                                    |                             | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Unknown</b>                                      |                            |
| 6. Length of stay in Baltimore  |                             | D. STREET ADDRESS (If rural, give location) <b>18-2</b>  |                            |
| 7. SEX <b>F</b>   | 8. COLOR OR RACE <b>Col</b> | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>M.</b>  | 10. DATE OF BIRTH <b>7</b> |
| 11. AGE (In years last birthday) <b>56</b>  |                             | 12. Under 1 Year: Months: Days   |                            |
| 13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b> |                             | 14. KIND OF BUSINESS OR INDUSTRY _____   |                            |
| 15. BIRTHPLACE (State or foreign country) <b>Unknown</b>  |                             | 16. CITIZEN OF WHAT COUNTRY? _____   |                            |
| 17. FATHER'S NAME <b>Unknown</b>  |                             | 18. MOTHER'S MAIDEN NAME <b>Unknown</b>  |                            |
| 19. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)   |                             | 20. SOCIAL SECURITY NO. _____  |                            |
| 21. INFORMANT <b>Good Samaritan Hosp.</b>   |                             | 22. ADDRESS _____  |                            |

|  |   |   |
|--|---|---|
| 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br><b>170X I</b><br><b>Metastatic CARCINOMA OF The BRAIN</b> | 2. CAUSE OF DEATH<br><b>Metastatic CARCINOMA OF The BRAIN</b> | 3. INTERVAL BETWEEN ONSET AND DEATH<br><b>6 weeks</b>   |
| 4. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br><b>(B) CARCINOMA of the Right Breast</b>  | 5. DUE TO<br><b>OF The BRAIN</b><br><b>BREAST</b>             | 6. INTERVAL BETWEEN ONSET AND DEATH<br><b>3 1/2 yrs</b> |
| 7. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>_____  |   |   |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 19A. DATE OF OPERATION <b>1947</b>   |  | 19B. MAJOR FINDINGS OF OPERATION<br><b>Cancer of Right Breast, Removed</b>                                |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____            |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____      |  |
| 22A. TIME (Month) (Day) (Year) (Hour) _____  |  | 22B. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 22C. HOW DID INJURY OCCUR? _____  |  |
| 23. I hereby certify that I attended the deceased from <b>JANUARY 1, 1950</b> , to <b>JUNE 27, 1950</b> , that I last saw the deceased alive on <b>June 26, 1950</b> , and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE<br><b>Melvin N. Burden</b>  |  | 23B. ADDRESS<br><b>2030 W. Fayette ST</b>   |  | 23C. DATE SIGNED<br><b>6/27/50</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <b>B</b>   |  | 24B. DATE <b>7/1/50</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY <b>Mt Calvary</b>                                |  |
| 24D. LOCATION (City, town, or county) <b>Baltimore Md</b>  |  | 24E. FUNERAL DIRECTOR <b>Joseph L. Rann</b>   |  | 24F. ADDRESS <b>1201 Mc Card St</b>   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 1 - 1950</b>  |  | REGISTRAR'S SIGNATURE<br><b>Thurston Williams, M.D.</b>   |  | 25. FUNERAL DIRECTOR <b>Joseph L. Rann</b>  |  |

IN SENATE,  
January 10, 1907.

REPORT OF THE  
COMMISSIONER OF THE LAND OFFICE  
FOR THE YEAR 1906.

ALBANY: JAMES B. LEECH, STATE PRINTER,  
1907.

Price, 10 CENTS.

For sale by the State Printer.

Also by the State Printer.

Also by the State Printer.

Also by the State Printer.

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Also by the State Printer.

235

50 5786

BIRTH NO. 60-13550

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5786

Registered No.

1. NAME OF DECEASED  
(Type or Print)

Baby boy Bogdan

2. DATE  
OF  
DEATH

6/30/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE

B. COUNTY

before admission)

5. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

Bon Secours Hosp.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Balto 6-01

6. STREET ADDRESS (If rural, give location)

103 N. Steeple

7. Length of stay in Baltimore

Yrs.  
Mos.  
Days

8. SEX

Male

9. COLOR OR RACE

White

10. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

single

11. DATE OF BIRTH

June 30/50

12. AGE (In years last birthday)

If Under 1 Year  
Months: Days: Min.

4

13A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)13B. KIND OF BUSINESS OR  
INDUSTRY

14. BIRTHPLACE (State or foreign country)

Balto

15. CITIZEN OF  
WHAT COUNTRY?

16. FATHER'S NAME

Leon Bogdan

17. MOTHER'S MAIDEN NAME

Alma Bach

18. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give year or dates of service)19. SOCIAL  
SECURITY NO.

20. INFORMANT

ADDRESS

Leon Bogdan 103 N. Steeple

21. 762

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

cerebral anoxia

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B)

atelectasis lungs

(C)

Prematurity

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

22A. DATE OF OPERATION

22B. MAJOR FINDINGS OF OPERATION

23. AUTOPSY?

YES ☐ NO ☐24A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)24B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)24C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)25A. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

25B. INJURY OCCURRED

25C. HOW DID INJURY OCCUR?

WHILE AT  
WORK ☐ NOT WHILE  
AT WORK ☐26. I hereby certify that I attended the deceased from 6/30/50, 1950, to 6/30/1950 that I last saw the  
deceased alive on 6/30/1950, and that death occurred at 11<sup>00</sup> Am., from the causes and on the date stated above.

27A. SIGNATURE

D. Shohler

M. O.

27B. ADDRESS

Bon Secours Hosp.

27C. DATE SIGNED

6/30/50

28A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

28B. DATE

28C. NAME OF CEMETERY OR CREMATORY

28D. LOCATION (City, town, or county) (State)

Burial July 1/50

Holy Redeemer

Balto

DATE RECEIVED BY REGISTRAR'S SIGNATURE

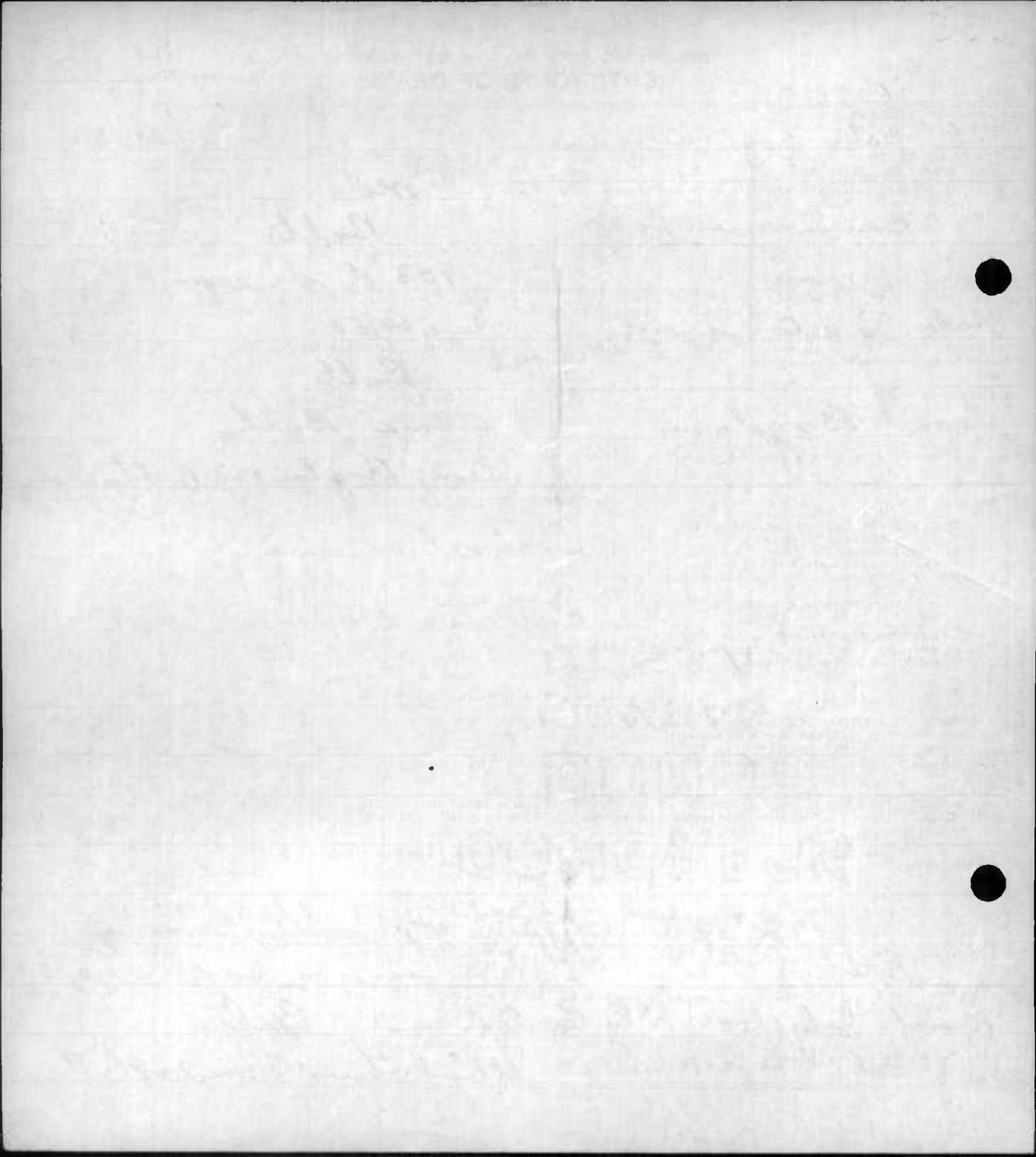
29. FUNERAL DIRECTOR

ADDRESS

JUL 1 - 1950

Ulrich Funeral Home 2008 Calver





420

50 5787

50 5787

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 50-13658

|   |                              |  |  |  |  |
|---|------------------------------|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Baby B Hallock "A"</b>  |                              |  | 2. DATE OF DEATH<br><b>6-30-50</b>   |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                              |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>md</b> B. COUNTY <b>Baltimore</b> |  |  |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Mercy Hospital</b>  |                              |  | C. CITY OR TOWN (If outside corporate limits, give RURAL and give township)<br><b>Baltimore, Md</b>                                    |  |  |
| 6. LENGTH OF STAY IN BALTIMORE<br><b>1</b>  |                              |  | D. STREET ADDRESS (If rural, give location)<br><b>8307 Old Bayview Rd</b>  |  |  |
| 7. SEX<br><b>M</b>  | 8. COLOR OR RACE<br><b>W</b> | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>single</b> | 10. DATE OF BIRTH<br><b>6/30/50</b>  |  | 11. AGE in years last birthday<br><b>1</b> |
| 10A. MAJOR OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>0</b> |                              |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>0</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>1</b>   |
| 13. FATHER'S NAME<br><b>Donald Hallock</b>  |                              |  | 14. MOTHER'S MAIDEN NAME   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>no</b>        |                              |  | 16. SOCIAL SECURITY NO.  |  |  |
| 17. INFORMANT   |                              |  | ADDRESS  |  |  |

|   |  |                                  |
|---|--|----------------------------------|
| 18. <b>762.5</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>adipose tissue</b><br>DUE TO<br><b>prevalence</b> |  | INTERVAL BETWEEN ONSET AND DEATH |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.          |  |                                  |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 19A. DATE OF OPERATION <b>0</b>   |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <b>6/30</b> to <b>6/30</b> , 19 <b>50</b> that I last saw the deceased alive on <b>6/30</b> , 19 <b>50</b> , and that death occurred at <b>2:15</b> p. m., from the causes and on the date stated above. |  |   |  |  |  |
| 23A. SIGNATURE<br><b>Dr. Joseph</b>   |  | 23B. ADDRESS<br><b>Mercy Hosp</b>   |  | 23C. DATE SIGNED<br><b>6/30/50</b>                                       |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>7/1/50</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Green Hill Rd</b>               |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore</b>   |  | 24E. NAME OF CEMETERY OR CREMATORY<br><b>Green Hill Rd</b>  |  | 24F. LOCATION (City, town, or county) (State)<br><b>Baltimore</b>        |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 1 - 1950</b>   |  | REGISTRAR'S SIGNATURE<br><b>Wm. Williams, M.D.</b>  |  | 25. FUNERAL DIRECTOR<br><b>J. J. Zahay &amp; Son</b>                     |  |
|   |  |   |  | ADDRESS<br><b>1315 Light St</b>  |  |

CERTIFICATE OF DEATH

State of New York

County of ...

City of ...

On the ... day of ...

at the age of ...

years, ...

... died ...

at ...

... after ...

... of ...

... was ...

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420

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5788

BIRTH NO. 5788 50-13559

1. NAME OF DECEASED (Type or Print) *Baby B Hollock "B"*

2. DATE OF DEATH *6/30/50*

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE *MD* B. COUNTY *Baltimore*

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) *Mercy Hospital*

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township) *Baltimore MD*

7. STREET ADDRESS (If rural, give location) *8307 Oak Harbor Rd*

8. LENGTH OF STAY IN BALTIMORE

9. SEX *M* 10. COLOR OR RACE *W* 11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) *single*

12. DATE OF BIRTH *6/30/50* 13. AGE (In years last birthday) *1* 14. If Under 1 Year: Months: Days 15. If Under 24 Hours: Hours: Min. *1*

16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *infant* 17. KIND OF BUSINESS OR INDUSTRY *none*

18. BIRTHPLACE (State or foreign country) *Maryland* 19. CITIZEN OF WHAT COUNTRY? *U.S.A.*

20. FATHER'S NAME *Donald Hollock* 21. MOTHER'S MAIDEN NAME

22. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) *no* 23. SOCIAL SECURITY NO.

24. INFORMANT ADDRESS

18. *726 X I* DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH (A) *Prematurity* DUE TO

INTERVAL BETWEEN ONSET AND DEATH *1 hour*

ANTECEDENT CAUSES (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION *0* 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

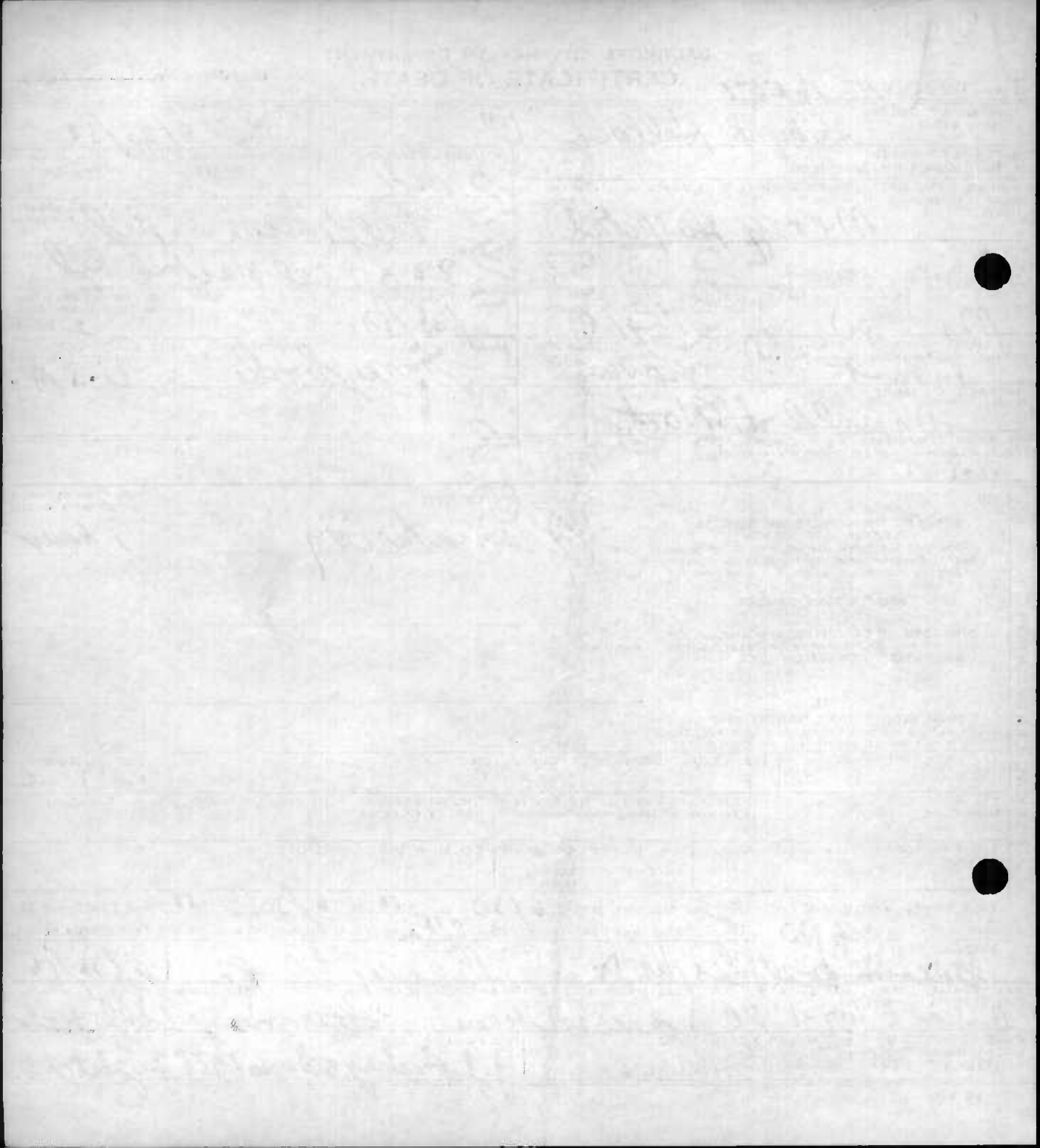
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *6/30*, 19*50*, to *6/30*, 19*50*, that I last saw the deceased alive on *6/30*, 19*50*, and that death occurred at *8:15* a.m., from the causes and on the date stated above.

23A. SIGNATURE *Donald Josephus, M.D.* M. D. 23B. ADDRESS *Mercy Hosp* 23C. DATE SIGNED *6/30/50*

24A. BURIAL, CREMATION, REMOVAL (Specify) *Burial* 24B. DATE *7-1-50* 24C. NAME OF CEMETERY OR CREMATORY *Sacred Heart* 24D. LOCATION (City, town, or county) (State) *German Hill Rd*

DATE RECEIVED BY LOCAL REGISTRAR *JUL 1 - 1950* REGISTRAR'S SIGNATURE *Wilmington Williams, M.D.* 25. FUNERAL DIRECTOR ADDRESS *J. J. Bahay & Sons 1318 Light St*



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 5789

250  
50 5789  
BIRTH NO. 50-13211

|   |                           |   |                                   |
|---|---------------------------|---|-----------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <u>CAMELLUS JACKSON</u>  |                           | 2. DATE OF DEATH <u>6-30-50</u>   |                                   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                           | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <u>MD.</u> B. COUNTY <u>BALT.</u> |                                   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><u>University Hosp.</u> |                           | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><u>BALT. 25-03A</u>                                 |                                   |
| 5. LENGTH OF STAY IN BALTIMORE <u>12</u> Yrs. Mos. Days   |                           | D. STREET ADDRESS (If rural, give location)<br><u>2624 Puget St.</u>  |                                   |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>C</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)   | 8. DATE OF BIRTH <u>June 1949</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                     |                           | 10B. KIND OF BUSINESS OR INDUSTRY   |                                   |
| 13. FATHER'S NAME <u>James Jackson</u>  |                           | 14. MOTHER'S MAIDEN NAME <u>Isabelle Haugter</u>  |                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>                                     |                           | 16. SOCIAL SECURITY NO.   |                                   |
| 17. INFORMANT   |                           | ADDRESS   |                                   |

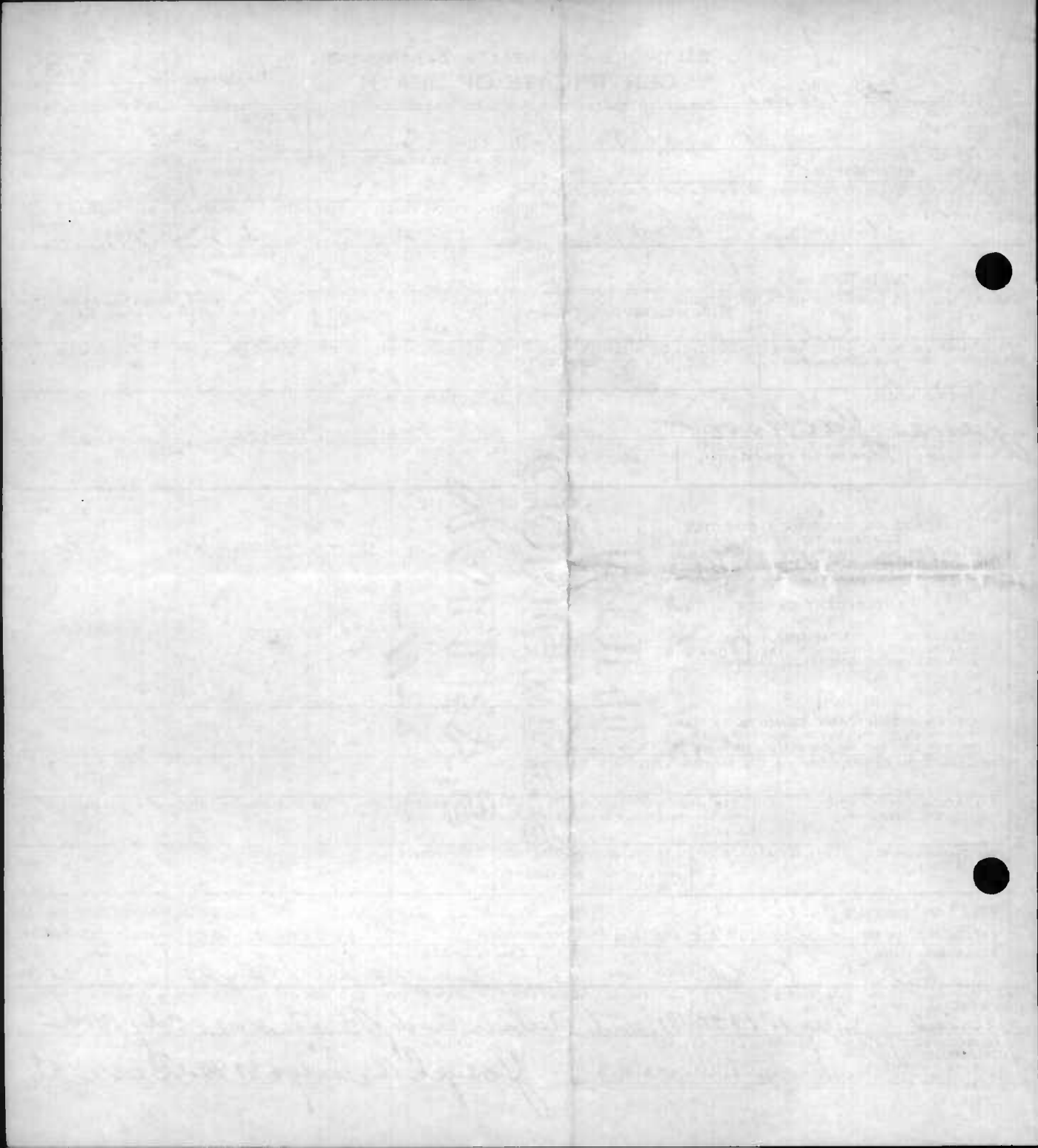
|   |  |                                  |
|---|--|----------------------------------|
| 18. <u>491X</u> I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><u>Bilat. Bronchopneumonia 5 days?</u> |  | INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO (A)  |  |                                  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  |                                  |
| DUE TO (B)  |  |                                  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |                                  |
| DUE TO (C)  |  |                                  |

|  |   |  |  |  |
|--|---|--|--|--|
| 19A. DATE OF OPERATION <u>0</u>              |   | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |  |

22. I hereby certify that I attended the deceased from 6-25, 1950, to 6-30, 1950, that I last saw the deceased alive on 6-30, 1950, and that death occurred at 7:45 A.M., from the causes and on the date stated above.

|   |                               |   |   |  |
|---|-------------------------------|---|---|--|
| 23A. SIGNATURE <u>Herbert K. Spure</u> M. D.            |                               | 23B. ADDRESS <u>University Hosp.</u>                        |   | 23C. DATE SIGNED <u>6-30-50</u>  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>July 1, 1950</u> | 24C. NAME OF CEMETERY OR CREMATORY <u>Mount Auburn Cem.</u> | 24D. LOCATION (City, town, or county) (State) <u>Baltimore City and</u> |  |
| DATE RECEIVED BY LOCAL REGISTRAR <u>JUL 1 - 1950</u>    |                               | REGISTRAR'S SIGNATURE <u>Wm. Williams, M.D.</u>             |   | 25. FUNERAL DIRECTOR <u>Joseph A. Lirly</u> ADDRESS <u>661 W. Bane St.</u> |





24  
M M 139304  
5790

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5790  
Registered No.

|  |                                  |   |  |   |  |
|--|----------------------------------|---|--|---|--|
| BIRTH NO.  |                                  | 1. NAME OF DECEASED<br>(Type or Print) <b>Joseph, Miraglia</b>  |  | 2. DATE OF DEATH<br><b>June 29, 1950</b>  |  |
| 3. PLACE OF DEATH:<br>a. <b>Baltimore City, Maryland</b>   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY |  |   |  |
| b. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>Baltimore City Hospitals</b><br><b>4940 Eastern Ave.</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>5-02</b>                |  |   |  |
| c. Length of stay in Baltimore <b>15 Years</b>   |                                  | d. STREET ADDRESS (If rural, give location)<br><b>302 N. Gay St.</b>  |  |   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>   | 8. DATE OF BIRTH<br><b>March 4, 1885</b> | 9. AGE (In years last birthday)<br><b>65</b>  | If Under 1 Year Months: Days If Under 24 Hours Hours: Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Barber</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Barber Shop</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Italy</b>                           |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                  | 13. FATHER'S NAME<br><b>Santo Miraglia (D)</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Angela Sefranta D.</b>                               |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS<br><b>Records B.C. H. 4940 Eastern Ave</b>                    |  |
| 18. <b>465X I</b> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Pulmonary Infarction.</b><br>DUE TO<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                                  |   |  |   |  |
| INTERVAL BETWEEN ONSET AND DEATH   |                                  |   |  |   |  |
| 19a. DATE OF OPERATION <b>0</b>  |                                  | 19b. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                                  | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                                   |  | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                  | 21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK                      |  | 21f. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>June 29, 1950</b> to <b>June 29, 1950</b> that I last saw the deceased alive on <b>June 29, 1950</b> and that death occurred at <b>7:50 PM</b> from the causes and on the date stated above.   |                                  |   |  |   |  |
| 23a. SIGNATURE<br><b>H. J. Jagan</b> M. D.   |                                  | 23b. ADDRESS<br><b>4940 Eastern Ave.</b>  |  | 23c. DATE SIGNED<br><b>June 29, 50</b>  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 24b. DATE<br><b>July 3rd 1950</b>   |  | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cemetery</b>                 |  |
| 24d. LOCATION (City, town, or county) (State)<br><b>4430 Belair Rd.</b>  |                                  | DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 1 - 1950</b>   |  | REGISTRAR'S SIGNATURE<br><b>Wilmington Williams, M.D.</b>                           |  |
| FUNERAL DIRECTOR<br><b>Frank DellaVoca</b>   |                                  | ADDRESS<br><b>322 S. High St.</b>   |  |   |  |



|   |  |   |  |  |  |
|---|--|---|--|--|--|
| P-452<br>50 5791  |  | CERTIFICATE CORRECTED 7-6-50  |  | X 50 5791  |  |
| BALTIMORE CITY HEALTH DEPARTMENT  |  |   |  | Registered No.   |  |
| CERTIFICATE OF DEATH  |  |   |  |  |  |
| BIRTH NO.   |  |   |  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>KENNETH Pierre BLANK</b>  |  |   |  | 2. DATE OF DEATH<br><b>July 1, 1950</b>  |  |
| 3. PLACE OF DEATH:<br>a. Baltimore City, Maryland   |  |   |  | 4. USUAL RESIDENCE (Where deceased lived before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Washington</b> |  |
| b. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Union Memorial Hospital</b>   |  |   |  | c. CITY OR TOWN<br><b>Hagerstown 7103</b>  |  |
| c. Month of stay in Baltimore   |  |   |  | d. STREET ADDRESS (If rural, give location)<br><b>96 Wyoming Ave.</b>  |  |
| 5. SEX<br><b>M</b>  |  | 6. COLOR OR RACE<br><b>W</b>  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>married</b>  |  |
| 8. DATE OF BIRTH<br><b>Aug. 16, 1899</b>  |  | 9. AGE (In years last birthday)<br><b>50</b>  |  | 10. Under 1 Year<br>Months: Days: Hours: Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Railway Engineer</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>  |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>C. Roy Plank</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Virgie Plank</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>Yes</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>705-10-7656</b>  |  |
| 17. INFORMANT   |  |   |  | ADDRESS  |  |
| 18. <b>331X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cerebral Vascular Accident (Cerebral Hemorrhage)</b><br>DUE TO<br>(A) <b>Cerebral Vascular Accident (Cerebral Hemorrhage)</b><br>DUE TO<br>(B)<br>DUE TO<br>(C)<br>DUE TO<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>DUE TO |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 Day</b>   |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. MAJOR FINDINGS OF OPERATION   |  |
| 20. AUTOPSY<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  |  |
| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |
| 21d. TIME (Month) (Day) (Year) (Hour) INJURY  |  | 21e. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.   |  |   |  |  |  |
| 23a. SIGNATURE<br><b>Alvin Bouzgas m.d. m. d.</b>   |  |   |  | 23b. ADDRESS<br><b>Union Memorial Hosp.</b>  |  |
| 23c. DATE SIGNED<br><b>July 1, 1950</b>   |  |   |  |  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24b. DATE<br><b>7-3-50</b>  |  | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>  |  |
| 24d. LOCATION (City, town, or county) (State)<br><b>Hagerstown, Md</b>  |  | 24e. FUNERAL DIRECTOR<br><b>Andrew R. Coffman</b>   |  | 24f. ADDRESS<br><b>Hagerstown</b>  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 2 - 1950</b>   |  | REGISTRAR'S SIGNATURE<br><b>Walter J. Williams, M.D.</b>  |  | 25. FUNERAL DIRECTOR<br><b>Andrew R. Coffman</b>   |  |
| VS 150  |  | 541 50  |  | 83a m.d.   |  |

UNITED STATES OF AMERICA

*[Faint, illegible text throughout the page, likely bleed-through from the reverse side.]*

L-100

50 5792

CERTIFICATE CORRECTED 8-10-50

50 5792

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH HEVY

2. DATE  
OF  
DEATH

6-30-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

4115 Roland View Ave

C. Length of stay in Baltimore

15 Yrs.  
Mon.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

married

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Grocer

10B. KIND OF BUSINESS OR  
INDUSTRY

self

13. FATHER'S NAME

Max

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

8. DATE OF BIRTH

July 15, 1890

9. AGE (In years  
last birthday)

59 (60)

11 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Theresa

17. INFORMANT

Gene Hevy

ADDRESS

Same

18. 420 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

Coronary Occlusion about

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Coronary thrombosis

10  
year

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21. TIME (Month) (Day) (Year) (Hour)

INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May-1-1950 to June-16, 1950, that I last saw the deceased alive on June-16, 1950, and that death occurred at 11:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Herman Seidel

23B. ADDRESS

2404 Eutaw Pl

23C. DATE SIGNED

7/1/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

7-2-50

24C. NAME OF CEMETERY OR CREMATORY

Hebrew Herring Run

24D. LOCATION (City, town, or county)

Baltimore

Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

J. C. Lewis

ADDRESS

2100 Eutaw Pl

JUL 2-1950

VS 150

15267

94a

MEDICAL CERTIFICATION



MAIL ROOM

B-430

50 5793

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5793

Registered No.

BIRTH NO.

|   |                                  |  |  |  |  |
|---|----------------------------------|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>BLEDY, Else</b>   |                                  |  | 2. DATE OF DEATH <b>July 1, 1950</b>   |  |  |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>  |                                  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>US Marine Hospital</b><br><b>Wyman Park Dr. &amp; 31 St., Balto. Md.</b> |                                  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>13-02</b>                  |  |  |
| D. STREET ADDRESS (If rural, give location)<br><b>2359 Eutaw Place</b>  |                                  |  | 5. LENGTH OF STAY IN BALTIMORE<br><b>11 yrs 6 mos</b>  |  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Wid.</b> | 8. DATE OF BIRTH<br><b>Mar. 19, 1887</b>   |  | 9. AGE (In years last birthday)<br><b>63</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY                              | 11. BIRTHPLACE (State or foreign country)<br><b>Austria</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>CSA</b>   |
| 13. FATHER'S NAME<br><b>M. Reich</b>  |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>Sophie Ehrenfeld</b>  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>Unknown</b>   |                                  | 16. SOCIAL SECURITY NO.  | 17. INFORMANT ADDRESS<br><b>Records, US Marine Hospital, Balto., Md.</b>   |  |  |

|   |  |  |
|---|--|--|
| 18. <b>SOIX</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Modgkin's Disease, generalized</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>7 mos</b> |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>(A) DUE TO</b>   |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>(B) DUE TO</b>  |  |  |
| <b>(C)</b>  |  |  |

|  |   |   |  |   |
|--|---|---|--|---|
| 19A. DATE OF OPERATION <b>7-1-50</b>   |   | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |   |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |  |   |
| 22. I hereby certify that I attended the deceased from <b>June 11, 1950</b> to <b>July 1, 1950</b> , that I last saw the deceased alive on <b>July 1, 1950</b> , and that death occurred at <b>11:30 A. m.</b> , from the causes and on the date stated above. |   |   |  |   |
| 23A. SIGNATURE<br><b>J. L. Lewis Jr. MD. O. O. D.</b>  |   | 23B. ADDRESS<br><b>US Marine Hospital, Baltimore, Md.</b>                 |  | 23C. DATE SIGNED<br><b>7-1-50</b>   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 24B. DATE<br><b>7-2-50</b>  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Arlington</b>                    | 24D. LOCATION (City, town, or county) (State)<br><b>Balto Md</b> |   |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>7-2-1950</b>  | REGISTRAR'S SIGNATURE<br><b>Wilmington Williams</b>   | 25. FUNERAL DIRECTOR<br><b>Jack Lewis</b> ADDRESS<br><b>2100 Eutaw Rd</b> |  |   |

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE AT BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

H-200  
50 5794BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5794  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

LIZZIE HAYES

2. DATE  
OF  
DEATH

6-29-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

1439 ARGYLE AVE.

C. Length of stay in Baltimore

20 YEARS

Yrs.  
Mos.  
Days

5. SEX

FEMALE

6. COLOR OR RACE

COLORED

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

WIDOWED

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR  
INDUSTRY

AT HOME

13. FATHER'S NAME

BENJAMIN HIGH

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)A. STATE  
MARYLAND

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE 17. 14-02

D. STREET ADDRESS (If rural, give location)

1439 ARGYLE AVE.

8. DATE OF BIRTH

APRIL 1879 71

9. AGE (In years;  
last birthday)

11 Under 1 Year 11 Under 24 Hours

Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

LOUISBURG, N.C.

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

14. MOTHER'S MAIDEN NAME

SARAH SYKES

17. INFORMANT

ADDRESS

JESSIE HENDRICKS-1432 ARGYLE AVE.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) .....

DUE TO

Bronchogenic Carcinomatosis

(7.)

ANTECEDENT CAUSES

(B) .....

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

II

(C) .....

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 8, 1949, to June 29, 1950, that I last saw the deceased alive on June 28, 1950, and that death occurred at 69 m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

5117, Schuler St. Baltimore Md

6/30/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Wm. A. Jackson, M.D.

Wm. A. JACKSON-916 PENNA. AVE.

JUL 26-1950

47c

VALLEY

of

C-632 5795

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5795  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

SEWELL RUSSELL (CORTEZ) COURTS

2. DATE  
OF  
DEATH

July 1, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

St. Joseph's Hospital

C. Length of stay in Baltimore 32 yrs.

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

D.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1906 N. Longwood Street

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Plumbing Supervisor

10B. KIND OF BUSINESS OR  
INDUSTRY

Contractor

8. DATE OF BIRTH

Nov. 29 1890

9. AGE (in years  
last birthday)

59 yrs

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Harvey T. Courts

14. MOTHER'S MAIDEN NAME

Carrie F. Owings

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

216-07-4521

17. INFORMANT

Mrs Jessie C. Hollenberry 1906 Longwood St  
Balto Md

18. E 819.4

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Multiple lacerations and abrasions

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE, (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Intraperitoneal hemorrhage

DUE TO rupture of liver

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
PRIMARY ☒ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

Park

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Valve House--Clifton Park

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

July 1, 1950

2:10 A.M.

21E. INJURY OCCURRED  
WHILE AT ☐ WORK  
NOT WHILE ☒ AT WORK

21F. HOW DID INJURY OCCUR?

Auto into valve house (driver)

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley S. Durlacher M.D.

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

23C. DATE SIGNED

7-1-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

July 4 1950

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge Cemetery

24D. LOCATION (City, town, or county)

Pikesville Md

DATE RECEIVED BY  
LOCAL REGISTRAR

JUL 2 - 1950

REGISTRAR'S SIGNATURE

William J. Williams, M.D.

25. FUNERAL DIRECTOR

Wm Berryman &amp; Sons Reisterstown Md

ADDRESS

VS 151

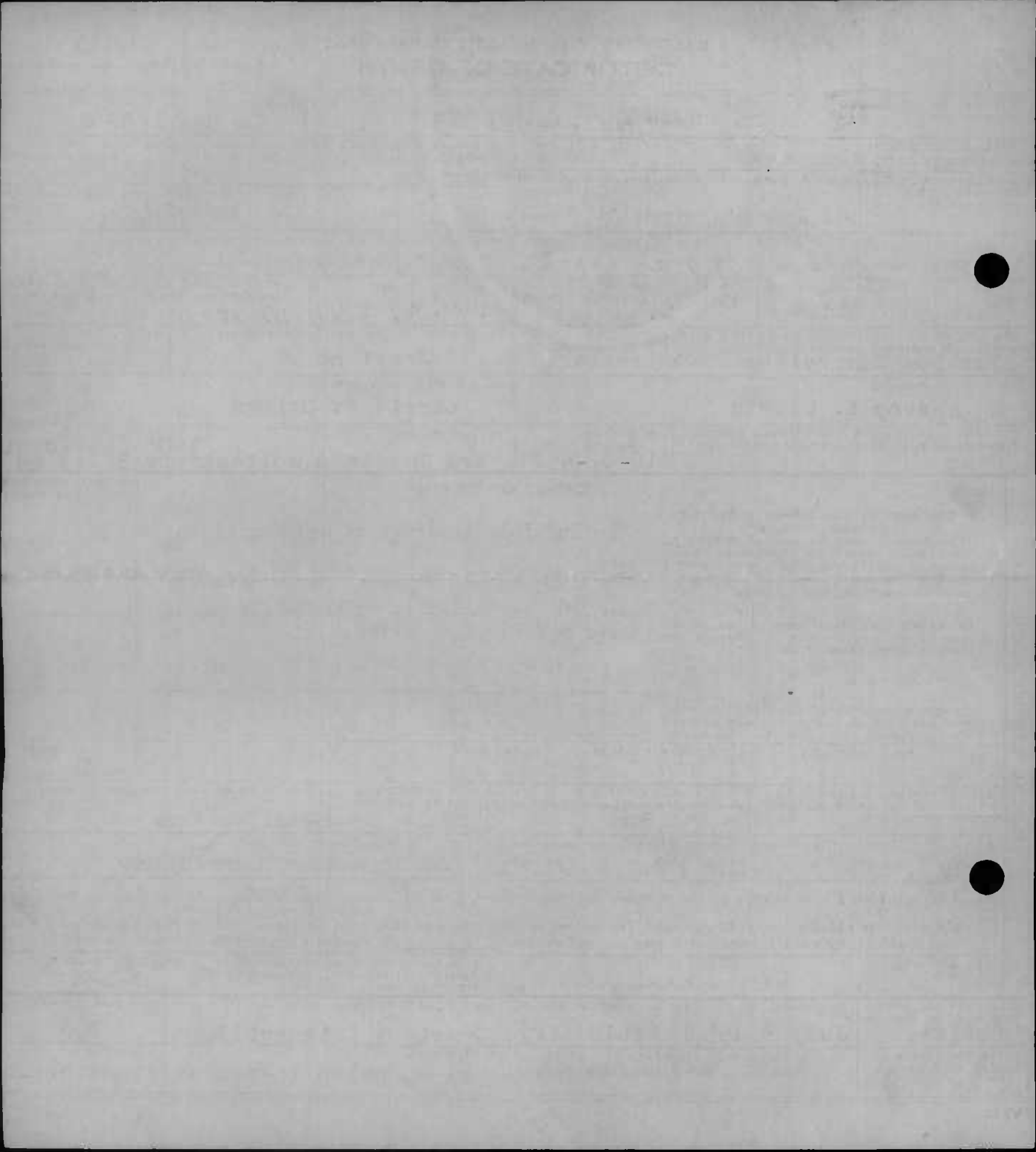
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290 24

170C

MEDICAL CERTIFICATION





B-120

50 5796

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5796

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

William J Bavis

2. DATE  
OF  
DEATH

June 29, 1950.

3. PLACE OF DEATH:

A. Baltimore City, Maryland 2796 1/2 Tivoly Ave

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

2796 1/2 Tivoly Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE  
B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore City 9-06

D. STREET ADDRESS (If rural, give location)

2796 1/2 Tivoly Ave

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Single

8. DATE OF BIRTH

February 26 1909

9. AGE (In years,  
last birthday)

41

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR  
INDUSTRY

Office Penn Railroad

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

William J Bavis

14. MOTHER'S MAIDEN NAME

Mary Stevenson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.  
717-07-7864

17. INFORMANT

ADDRESS

Charles Bavis (Brother) 2796 1/2 Tivoly

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Carcinoma of Rectum

2 1/2 yrs

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

July, 1948.

Carcinoma of Rectum

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)22A. TIME (Month) (Day) (Year) (Hour)  
INJURY

22B. INJURY OCCURRED

22C. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK22. I hereby certify that I attended the deceased from June 1948 to June 29, 1950 that I last saw the  
deceased alive on June 29, 1950, and that death occurred at 7:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Wm. H. Greuzer M.D.

1520 E. 33rd St

6-30-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

July 3, 1950

New Cathedral

Baltimore

Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Thurston Williams, M.D.

J. Melville Jenkins 2713 Kirk Ave Baltimore

JUL 2 - 1950

VS 150

26647

467

MEDICAL CERTIFICATION

REPUBLIC OF THE PHILIPPINES  
DEPARTMENT OF AGRICULTURE  
BUREAU OF SUGAR  
OFFICE OF THE SUGAR COMMISSIONER

Form No. 1



H-400  
50 5797BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 5797

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Joseph R. Hill

2. DATE  
OF  
DEATH

6/30/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Annapolis Hospital

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md

B. COUNTY

C. CITY OR TOWN

BALTO

(If outside corporate limits, write RURAL and give township)

24-03

D. STREET ADDRESS (If rural, give location)

1134 RIVERSIDE AVE

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

Dec 29, 1898

9. AGE (In years  
last birthday)11 Under 1 Year  
Months Days Hours Min.

51

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

PRINTER

COMMERCIAL

11. BIRTHPLACE (State or foreign country)

BALTO

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

JOHN WM HILL

14. MOTHER'S MAIDEN NAME

BELLE CONDON

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

NO

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

215-01-790

17. INFORMANT

ADDRESS

Mrs MARGARET Hill

SAME

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Nervous & Pulmonary Edema  
from drug poisoning

1 WK

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Hypertensive Arteriosclerosis

Cardiovascular Disease

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/23, 1950, to 6/30, 1950, that I last saw the deceased alive on 6/30, 1950, and that death occurred at 10:59 pm., from the causes and on the date stated above.

23A. SIGNATURE

J. K. Hill

23B. ADDRESS

Annapolis Hosp

23C. DATE SIGNED

7/1/50

24A. BURIAL, CREMA-  
TION REMOVAL (Specify)

24B. DATE

7/5/50

24C. NAME OF CEMETERY OR CREMATORY

Glenhaven Mem

24D. LOCATION (City, town, or county)

Annapolis Rd

(State)

Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wm. J. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Theodore J. Bleight 6009 Harbor Rd

JUL 2 1950

31014

937

CERTIFICATE OF EVIDENCE

IN THE MATTER OF THE ESTATE OF

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M-200  
50 5798

50 5798

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

BESSIE M. MCKEE

2. DATE  
OF  
DEATH

JUNE 30, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

1516 RAMSAY ST

C. Length of stay in Baltimore

8 yrs

Yrs.  
Mos.  
Days

4. SEX

FEMALE White

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

WIDOW

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE 19-03

D. STREET ADDRESS (If rural, give location)

1516 RAMSAY ST

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

NONE

10B. KIND OF BUSINESS OR INDUSTRY

8. DATE OF BIRTH

MAY 8, 1892

9. AGE (In years last birthday)

58

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

11. BIRTHPLACE (State or foreign country)

UNION W. V.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

JAMES W. LAWRENCE

14. MOTHER'S MAIDEN NAME

MARGARET BURNS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

NONE

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

MARGUERITE L. PASKY RAMSAY ST

18. 420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Coronary Insufficiency

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

(C)

INTERVAL BETWEEN ONSET AND DEATH

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

21G. INJURY

m.

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from June 26, 1950, to June 30, 1950, that I last saw the deceased alive on June 30, 1950, and that death occurred at 10:15 pm., from the causes and on the date stated above.

23A. SIGNATURE

L. H. Solombeck M.D.

23B. ADDRESS

3404 West Park Ave

23C. DATE SIGNED

7/1/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

7/4/50

24C. NAME OF CEMETERY OR CREMATORY

Green Haven Cem

24D. LOCATION (City, town, or county) (State)

A. A. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Christington Williams, M.D.

25. FUNERAL DIRECTOR

Post O. B. M. Walter

ADDRESS

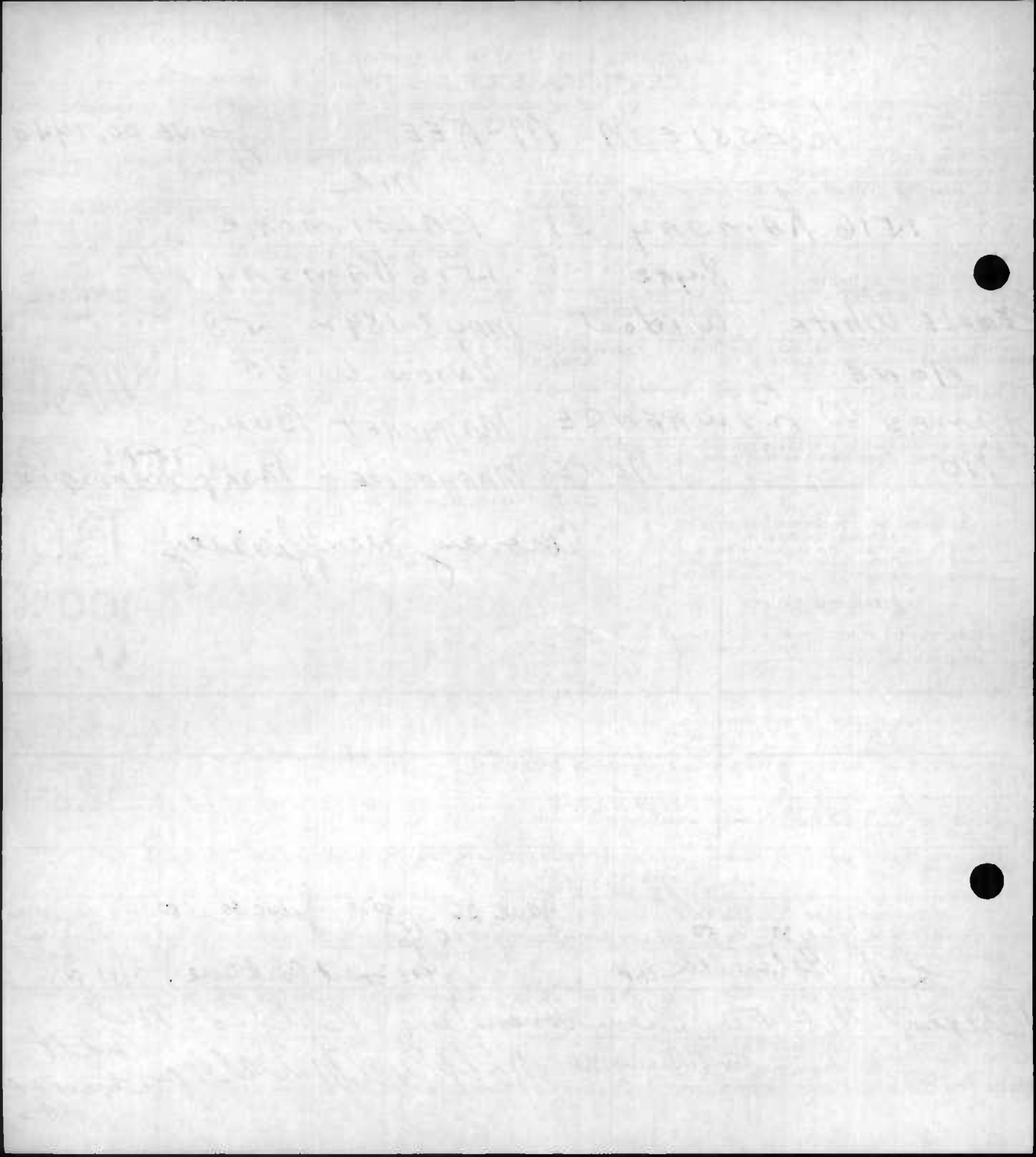
JUL 2-1950

VS 150

94a

MEDICAL CERTIFICATION





M-526  
50 5799

50 5799

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Anna Manger

2. DATE

OF DEATH June 30/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR INSTITUTE) General German Aged Peoples

Home, 22 S. Athol Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

28-04

D. STREET ADDRESS (If rural, give location)

22 S. Athol Ave.

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

May 3, 1860

9. AGE (in years

last birthday)

90

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

George Kreutzer

14. MOTHER'S MAIDEN NAME

Sabina Kaiser

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. J. Geo. Walz, Sect'y, 22 S. Athol Ave

18. 443X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Hypertensive Cardio Vascular

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Disease of cerebral hemispheres

DUE TO

(C) arteriosclerosis, generalized

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2 June, 1950, to 30 June, 1950, that I last saw the  
deceased alive on 30 June 1950, and that death occurred at 9 P. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

July 3/50

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge

24D. LOCATION (City, town, or county) (State)

Pikesville, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

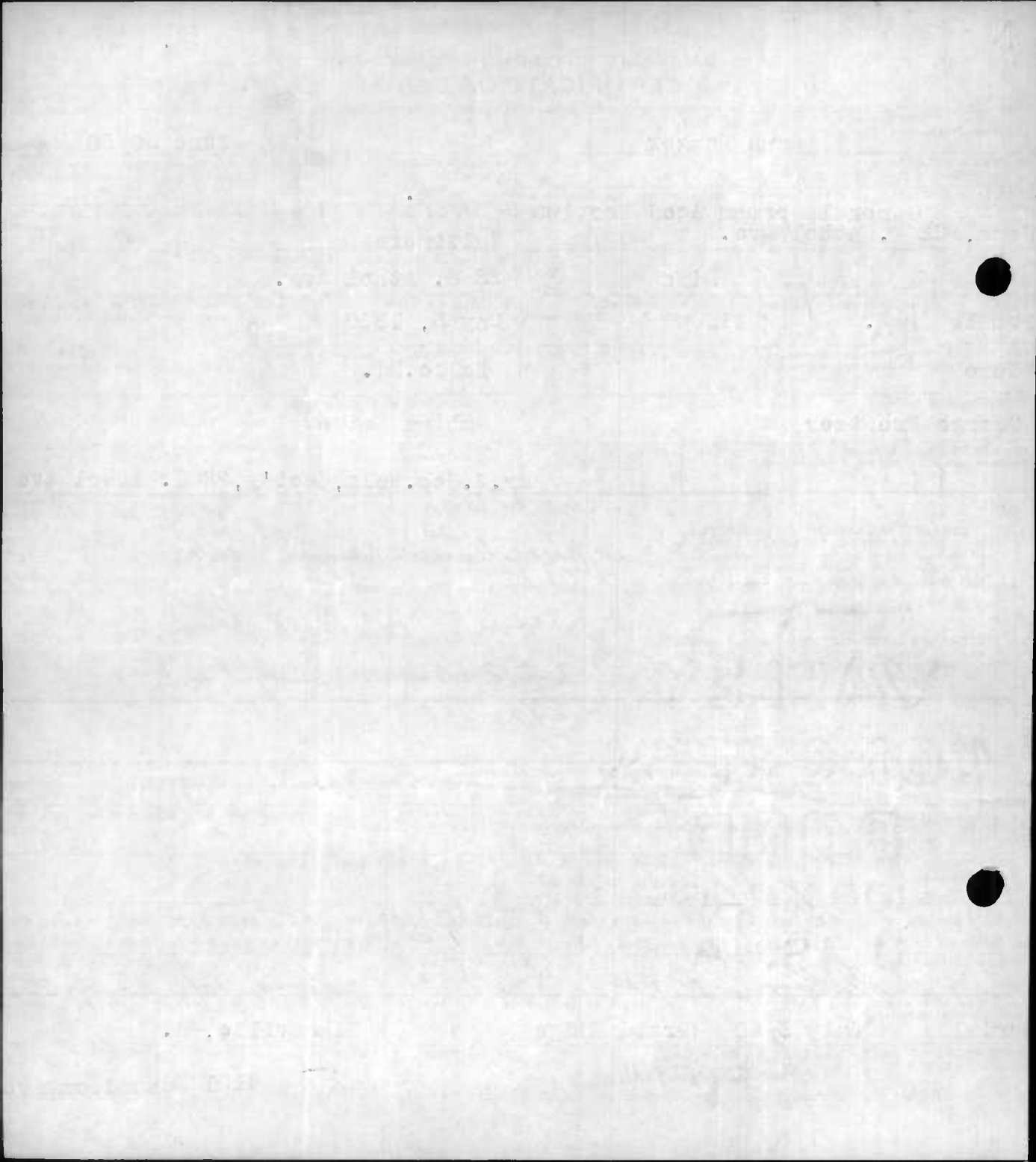
ADDRESS

JL 2-1950

VS 150

Huntington Williams, M.D. Harry H. Kutzke, 4101 Edmondson Ave

9317



P-420

50 5800

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 5800

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mother Mary Stella, U.S.O.

2. DATE  
OF  
DEATH

July 1, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR

INSTITUTION

St. Joseph's

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

6813 Belair Rd.

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (in years  
last birthday)H Under 1 Year  
Months: Days  
H Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from June 6, 1950 to July 1, 1950, that I last saw the  
deceased alive on July 1, 1950, and that death occurred at 6:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

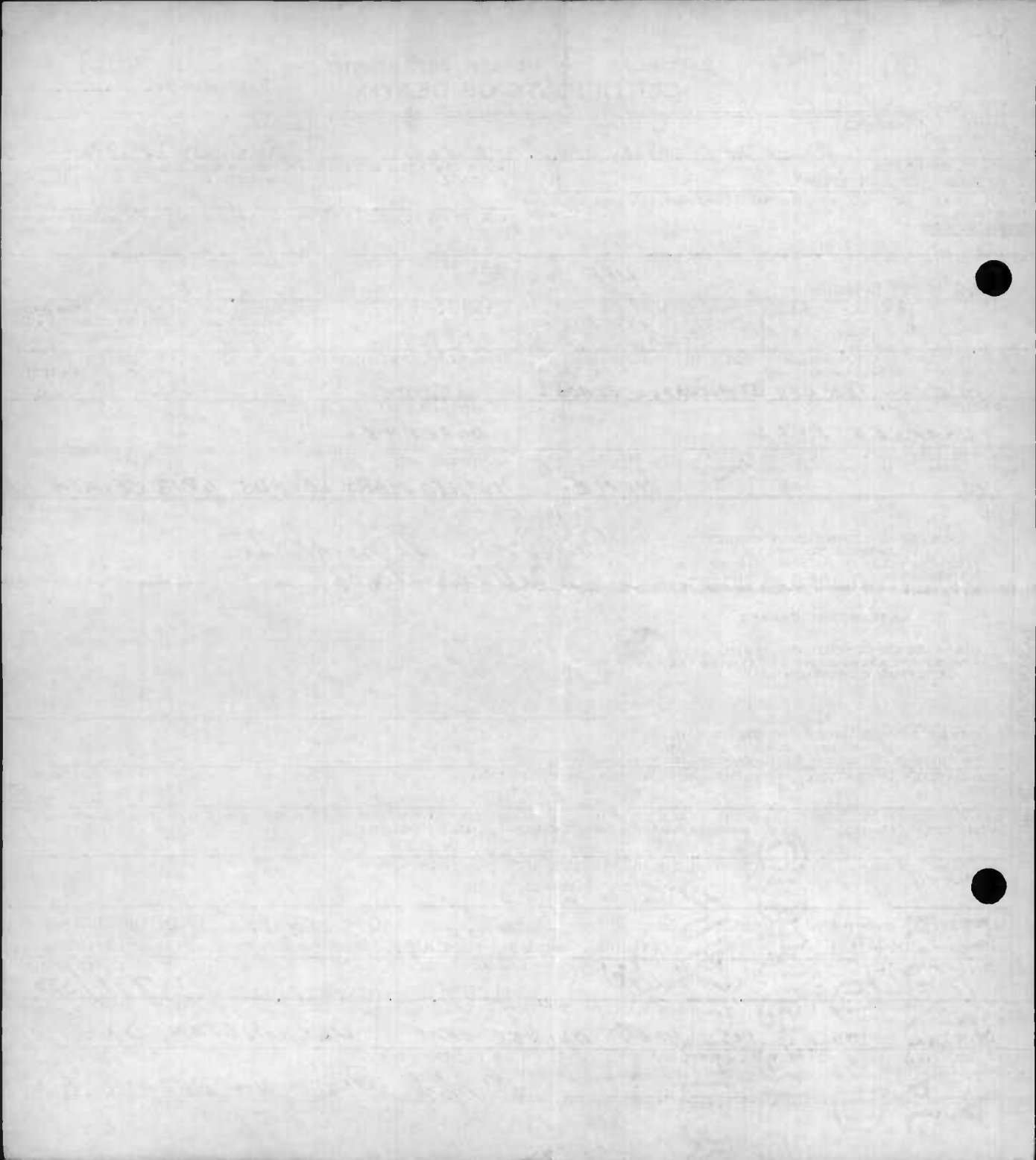
JUL 2 - 1950

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0938X

74a

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5801  
Registered No.

BIRTH NO.

|   |                                  |  |  |  |   |
|---|----------------------------------|--|--|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Emma Kirschmann</i>   |                                  |  | 2. DATE OF DEATH<br><i>6/29/50</i>   |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |  | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <i>MARYLAND</i><br>B. COUNTY _____ |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>00 204-S-PAYSON ST.</i>   |                                  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore</i> <i>20-03</i>                        |  |   |
| C. Length of stay in Baltimore<br><i>Life</i>   |                                  |  | D. STREET ADDRESS (If rural, give location)<br><i>204 S. PAYSON ST.</i>  |  |   |
| 5. SEX<br><i>Female</i>   | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Single</i> | 8. DATE OF BIRTH<br><i>MAY-18-1861</i>   |  | 9. AGE (In years, last birthday)<br><i>89</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>At Home</i> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>At Home</i>              | 11. BIRTHPLACE (State or foreign country)<br><i>Baltimore Md.</i>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i> |
| 13. FATHER'S NAME<br><i>Rev. G. Kirschmann</i>  |                                  |  | 14. MOTHER'S MAIDEN NAME<br><i>Elizabeth Geiger</i>  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><i>No</i>              |                                  | 16. SOCIAL SECURITY NO.<br>_____                                 | 17. INFORMANT ADDRESS<br><i>MARTHA J. GARVIN - Same</i>  |  |   |

|  |  |  |  |   |
|--|--|--|--|---|
| 18. <i>331X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  | CAUSE OF DEATH<br>(A) <i>Cerebral Hemorrhage</i><br>DUE TO<br>(B) <i>Arteriosclerosis</i><br>DUE TO<br>(C) <i>Hypertension</i> |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>3 days</i><br><i>7</i><br><i>2</i> |
|--|--|--|--|---|

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 19A. DATE OF OPERATION<br><i>0</i>   |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <i>6/26</i> , 19 <i>50</i> , to <i>6/29</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>6/29</i> , 19 <i>50</i> , and that death occurred at <i>4:10 p.m.</i> , from the causes and on the date stated above. |  |  |  |   |  |
| 23A. SIGNATURE<br><i>Samuel K. [illegible]</i>   |  | 23B. ADDRESS<br><i>721 Medical City Bldg</i>   |  | 23C. DATE SIGNED<br><i>6/30/50</i>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  |  | 24B. DATE<br><i>Burial July 3/50</i>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>London Park</i>                            |  |
| 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore Md.</i>  |  | 25. FUNERAL DIRECTOR<br><i>H. B. [illegible]</i>   |  | ADDRESS<br><i>1300 Eutan Pl. 17</i>   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>2-1950</i>  |  | REGISTRAR'S SIGNATURE<br><i>Wm. [illegible]</i>  |  | FEE<br><i>\$39</i>  |  |



1891

CERTIFICATE OF DEATH

State of New York

County of ...

City of ...

On the ... day of ...

at the age of ...

years ...

months ...

days ...

hours ...

minutes ...

seconds ...

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W-352  
50 5802

50 5802

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION  
South Baltimore General Hospital

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Mechanic

10B. KIND OF BUSINESS OR INDUSTRY

Automobile

13. FATHER'S NAME

Edward Whittington

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

No

(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

579-01-4131

2. DATE OF DEATH

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

D. STREET ADDRESS (If rural, give location)

1602 Marshall Street

8. DATE OF BIRTH

July 22 1905

9. AGE (In years last birthday)

44

11. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.

14. MOTHER'S MAIDEN NAME

Elizabeth Ford

17. INFORMANT

Mrs. Emma J. Whittington

ADDRESS

1602 Marshall Street

18. 420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

Myocardial infarction

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

Coronary occlusion

DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.Hypertensive Cardiovascular disease  
Paraplegia

DUE TO

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)

INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-30-1950 to 7-1-1950 that I last saw the deceased alive on 7-1-1950, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 2 1950

55083

937

MEDICAL CERTIFICATION

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

Form No. 1

Investigation of

Case No.

Date

Place

Subject

Reference

Remarks

Signature

Special Agent in Charge

Investigator

Supervisor

Director

Chief of Bureau

Assistant Director

Administrative Assistant

Records and Communications

Training and Development

Legal Counsel

P-536  
50 5803BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 5803

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Patricia Pinder

2. DATE  
OF  
DEATH

July 2, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, If institution: residence  
A. STATE B. COUNTY before admission)

Del.

V-07

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Wilmington

D. STREET ADDRESS (If rural, give location)

579 Shipside

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Child

8. DATE OF BIRTH

10-3-41

9. AGE (in years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Leonard Pinder

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 754.4

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Cardiac Failure  
following operation  
for

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Congenital Heart Disease

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

7/1/50

19B. MAJOR FINDINGS OF OPERATION

Congenital Heart Disease

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-30-, 1950 to 7-2-, 1950, that I last saw the  
deceased alive on 7-2-, 1950, and that death occurred at 9:35 a. m., from the causes and on the date stated above.

23A. SIGNATURE

JNP Johns

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

July 3, 1950

24C. NAME OF CEMETERY OR CREMATORY

Odd Fellows

24D. LOCATION (City, town, or county)

Smyrna Del.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Wm. J. Tichenor &amp; Son, Baltimore, Md.

ADDRESS

cardiac failure  
for  
pericardial heart disease  
operation

x      congestive heart disease

5/1/20

CHB form

H-635  
50 5804BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5804

|  |                                  |  |  |   |  |
|--|----------------------------------|--|--|---|--|
| BIRTH NO.  |                                  | 1. NAME OF DECEASED<br>(Type or Print) <i>Margaret A. Hartman</i>  |  | 2. DATE OF DEATH <i>June 30-50</i>  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Md.</i> B. COUNTY   |  | 5. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 7-02</i> |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>5-20 N. Glover St.</i>   |                                  | D. STREET ADDRESS (If rural, give location)<br><i>520 N. Glover St.</i>  |  | 6. LENGTH OF STAY IN BALTIMORE<br>Yrs. Mos. Days  |  |
| 5. SEX<br><i>Female</i>  | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Widow</i>  | 8. DATE OF BIRTH<br><i>June 3-1879</i> | 9. AGE (In years last birthday)<br><i>71</i>  | 10. UNDER 1 Year Months: Days 11. UNDER 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housework</i>  |                                  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><i>Balto.</i>  |  |
| 12. CITIZEN OF WHAT COUNTRY?   |                                  | 13. FATHER'S NAME<br><i>Christopher Medicus</i>  |  | 14. MOTHER'S MAIDEN NAME<br><i>Not Known</i>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br><i>Henry Hartman 6410 Gerland Ave.</i>                                       |  |
| 18. <i>4200 I</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                                  | CAUSE OF DEATH<br>(A) <i>Arteriosclerotic Heart Disease</i><br>DUE TO<br><i>Acute Cardiac Failure</i><br>(B)<br>DUE TO<br><i>Generalized Arteriosclerosis</i><br>(C)<br>INTERVAL BETWEEN ONSET AND DEATH<br><i>5 yrs.</i><br><i>1/2 hour.</i><br><i>5 yrs.</i> |  |   |  |
| 19A. DATE OF OPERATION <i>0</i>  |                                  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |                                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                              |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <i>June 1, 1945</i> to <i>June 30, 1950</i> that I last saw the deceased alive on <i>May 30, 1950</i> and that death occurred at <i>1:00</i> m., from the causes and on the date stated above.  |                                  |  |  |   |  |
| 23A. SIGNATURE<br><i>Ernest Roun</i>   |                                  | 23B. ADDRESS<br><i>2413E Monmouth St.</i>  |  | 23C. DATE SIGNED<br><i>7/1/50</i>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                                  | 24B. DATE<br><i>July 3-50</i>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Baltimore Cem.</i>   |  |
| 24D. LOCATION (City, town, or county) (State)<br><i>Balto. Md.</i>   |                                  | 25. FUNERAL DIRECTOR<br><i>John L. Pfitzer</i>   |  | 25. ADDRESS<br><i>2334 Jefferson St.</i>  |  |

MEDICAL CERTIFICATION



EXAMINED IN THE COURT OF THE  
HONORABLE JUSTICE OF THE PEACE

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

BIRTH NO. \_\_\_\_\_ Registered No. \_\_\_\_\_

|   |                                  |   |  |  |  |  |  |
|---|----------------------------------|---|--|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Dorothy Elizabeth Lowe</b>  |                                  |   |  | 2. DATE OF DEATH <b>June 30, 1950</b>  |  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>Balto.</b> |  |  |  |
| 5. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTE <b>Baltimore City Hospitals</b><br><b>4940 Eastern Avenue</b> |                                  |   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <i>Middle River</i>                         |  |  |  |
| 6. Length of stay in Baltimore <b>Life</b>  |                                  |   |  | D. STREET ADDRESS (If rural, give location)<br><b>1714 Wilson Point Road</b> <b>5300</b>   |  |  |  |
| 7. SEX<br><b>Female</b>   | 8. COLOR OR RACE<br><b>White</b> | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b> |  | 10. DATE OF BIRTH<br><b>Jan. 21, 1878</b>  |  | 11. AGE (In years last birthday) <b>72</b> |  |
| 12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>  |                                  | 13. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>               |  | 14. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 15. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |  |
| 16. FATHER'S NAME<br><b>Whitzel</b>   |                                  |   |  | 17. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |  |  |  |
| 18. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>no</b>  |                                  |   |  | 19. SOCIAL SECURITY NO.<br><b>none</b>   |  |  |  |
| 20. INFORMANT ADDRESS<br><b>4940</b>  |                                  |   |  | 21. RECORDS: <b>Baltimore City Hospitals Eastern Av</b>  |  |  |  |

18. **332X I** CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Cerebral thrombosis due to**

DUE TO

ANTECEDENT CAUSES

(B) **Arteriosclerosis**

DUE TO

(C) \_\_\_\_\_

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **0** 19B. MAJOR FINDINGS OF OPERATION \_\_\_\_\_

20. AUTOPSY? YES ☐ NO ☒

|  |  |  |
|--|--|--|
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |

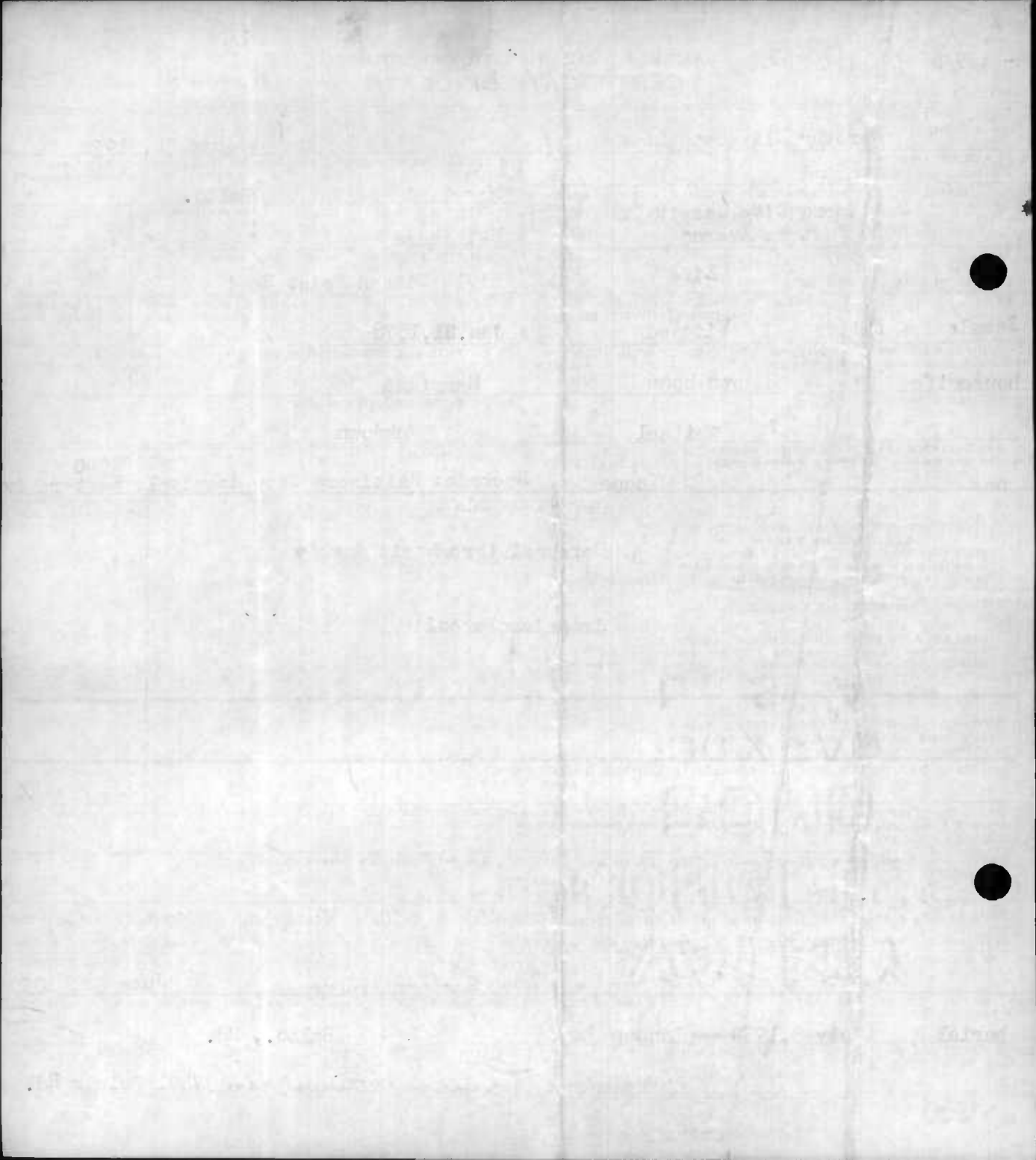
22. I hereby certify that I attended the deceased from **June 25**, 1950, to **June 30**, 1950 that I last saw the deceased alive on **June 30**, 1950, and that death occurred at **5 P. m.**, from the causes and on the date stated above.

23A. SIGNATURE **Ch. Cohen** M. D. **4940 Eastern Avenue** 23B. ADDRESS **4940 Eastern Avenue** 23C. DATE SIGNED **June 30, 1950**

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b> | 24B. DATE<br><b>July 3, 1950</b> | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b> | 24D. LOCATION (City, town, or county) (State)<br><b>Balto., Md.</b> |
|--|----------------------------------|--|---|

DATE RECEIVED BY LOCAL REGISTRAR \_\_\_\_\_ REGISTRAR'S SIGNATURE **Montgomery Williams, M.D.** 25. FUNERAL DIRECTOR **Lassabur Funeral Home** ADDRESS **7401 Belair Rd.**

3 1950 8312



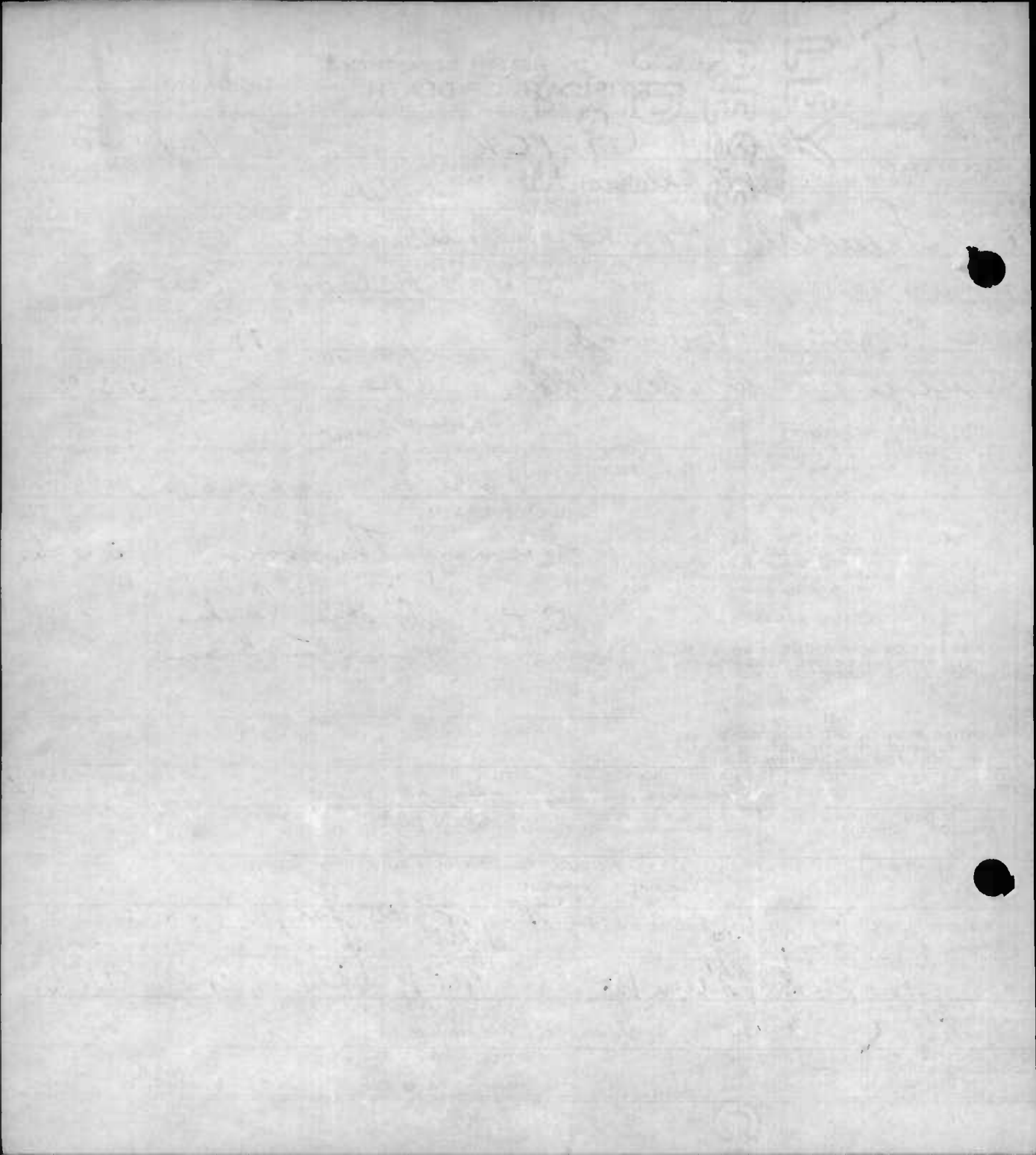
G-420  
50 5806

50 5806

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

|   |                               |   |                  |  |  |
|---|-------------------------------|---|------------------|--|--|
| BIRTH NO.   |                               | 1. NAME OF DECEASED<br>(Type or Print) <b>HARRY GRICK</b>   |                  | 2. DATE OF DEATH <b>7-1-50</b>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>121 No Ellamont St</b>   |                               | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD</b> B. COUNTY _____ |                  |  |  |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION <b>Fleublatt Home</b>   |                               | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 27-18</b>                         |                  |  |  |
| 6. Length of stay in Baltimore <b>50</b> Yrs. <input checked="" type="checkbox"/> Mos. <input type="checkbox"/> Days  |                               | D. STREET ADDRESS (If rural, give location) <b>5311 Nelson Ave</b>  |                  |  |  |
| 5. SEX <b>male</b>  | 6. COLOR OR RACE <b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>  | 8. DATE OF BIRTH | 9. AGE (In years last birthday) <b>71</b>  | 10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager</b>  |                               | 10B. KIND OF BUSINESS OR INDUSTRY <b>Coat and Cloth</b>   |                  | 11. BIRTHPLACE (State or foreign country) <b>Reesea</b>                          |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S. 9</b>  |                               | 13. FATHER'S NAME <b>Not Known</b>  |                  | 14. MOTHER'S MAIDEN NAME <b>Not Known</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes, no or unknown</b>  |                               | 16. SOCIAL SECURITY NO.   |                  | 17. INFORMANT ADDRESS <b>H. G. Grick 6006 Park Heights Ave</b>                   |  |
| 18. <b>420 / 1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  |                               | CAUSE OF DEATH  |                  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| ANTECEDENT CAUSES   |                               | (A) <b>Coronary Thrombosis</b>  |                  | <b>5 weeks</b>   |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |                               | (B) <b>Anteroseptal Cardiac Vascular Disease</b>  |                  | <b>?</b>   |  |
| II  |                               | (C)   |                  |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                               |   |                  |  |  |
| 19A. DATE OF OPERATION <b>0</b>   |                               | 19B. MAJOR FINDINGS OF OPERATION  |                  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                               | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                    |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)         |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |                               | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK                      |                  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <b>May 28, 1950</b> , to <b>July 1, 1950</b> , that I last saw the deceased live on <b>July 1, 1950</b> and that death occurred at <b>10:30 p.m.</b> , from the causes and on the date stated above. |                               |   |                  |  |  |
| 23A. SIGNATURE <b>Leon S. Blum</b>  |                               | 23B. ADDRESS <b>1100 N. Calvert St</b>  |                  | 23C. DATE SIGNED <b>7/1/50</b>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 24B. DATE <b>July 3, 1950</b>   |                  | 24C. NAME OF CEMETERY OR CREMATORY <b>Holmes Township</b>                        |  |
| 24D. LOCATION (City, town, or county) <b>Balto</b>  |                               | 24E. (State) <b>Md</b>  |                  |  |  |
| DATE RECEIVED BY LOCAL REGISTRAR <b>UL 3-1950</b>   |                               | REGISTRAR'S SIGNATURE <b>Huntington Williams</b>  |                  | 25. FUNERAL DIRECTOR ADDRESS <b>Jack Lewis Inc 2100 Eutaw Place</b>              |  |



4-451 5807

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5807  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Jeanette Lilienfeld

2. DATE  
OF  
DEATH

7-2-50

3. PLACE OF DEATH:

a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE

B. COUNTY

before admission)

b. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or  
location)

West Balto General

c. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore 15-11

c. Length of stay in Baltimore

15 1/2 Yrs.  
Months Days

d. STREET ADDRESS (If rural, give location)

3404 Lynchester Road

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

9. AGE (In years  
last birthday) 42  
If Under 1 Year Months Days  
If Under 24 Hours Hours Min.10a. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

House wife

10b. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Washington DC

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Max Sugar

14. MOTHER'S MAIDEN NAME

Rose

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.17. INFORMANT ADDRESS  
Dr Samuel Lilienfeld - Same

18. 170X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Carcinoma of breast - metastatic  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-2, 1950, to 7-2, 1950, that I last saw the  
deceased alive on 7-2, 1950, and that death occurred at 1:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Jerome Gabe

M. D.

23B. ADDRESS

West Balto. Gen.

23c. DATE SIGNED

7-2-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

7-4-50

24C. NAME OF CEMETERY OR CREMATORY

Washington

24D. LOCATION (City, town, or county) (State)

Balto

Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

H. H. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Jack Lewin 2100 Outaw Bk

3-1950

VS 150

50

MEDICAL CERTIFICATION



Called WB5H on 10/19/50

"Primary site was breast  
lump removed 3 yrs ago"

80

AB-128920

D-2603 5808

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5808

Registered No.

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Albert Duckworth</b>  |  |  | 2. DATE OF DEATH <b>June 30-1950</b>  |  |  |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY  |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>Baltimore City Hospitals</b><br><b>4940 Eastern Ave.</b> |  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>14-03</b>   |  |  |
| D. STREET ADDRESS (If rural, give location)<br><b>1313 W. North Ave.</b>  |  |  | E. DATE OF BIRTH<br><b>Aug. 21-1862</b>   |  |  |
| F. AGE (In years last birthday)<br><b>87</b>  |  |  | G. Under 1 Year Months Days<br>H. Under 24 Hours Hours Min.   |  |  |
| 5. SEX <b>M</b>   |  |  | 6. COLOR OR RACE <b>White</b>   |  |  |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b>   |  |  | 8. DATE OF BIRTH <b>Aug. 21-1862</b>  |  |  |
| 9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>   |  |  | 10. KIND OF BUSINESS OR INDUSTRY<br><b>Firm man</b>   |  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  |  | 12. CITIZEN OF WHAT COUNTRY?  |  |  |
| 13. FATHER'S NAME<br><b>(Unknown) Duckworth</b> (D)   |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b> (D)  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>No</b>  |  |  | 16. SOCIAL SECURITY NO.   |  |  |
| 17. INFORMANT <b>Baltimore City Hospitals</b><br><b>Records: 4940 Eastern Ave.</b>  |  |  | 18. CAUSE OF DEATH<br><b>E902.7</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic Heart Disease and Pulmonary Edema</b><br>DUE TO<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>Fracture of right femur</b> |  |  |
| 19A. DATE OF OPERATION <b>June 19-1950</b>  |  |  | 19B. MAJOR FINDINGS OF OPERATION<br><b>Fracture of right femur</b>  |  |  |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>   |  |  |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Baltimore City Hospitals</b>                         |  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>4940 Eastern Ave.</b>  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY<br><b>6-19-1950 1:20 PM</b>   |  |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |  |
| 21F. HOW DID INJURY OCCUR?<br><b>Patient fell out of bed (COVER)</b>  |  |  | 22. I hereby certify that I attended the deceased from <b>5-11</b> , 19 <b>49</b> , to <b>6-30</b> , 1950, that I last saw the deceased alive on <b>6-30</b> , 1950, and that death occurred at <b>1.20 PM</b> , from the causes and on the date stated above.  |  |  |
| 23A. SIGNATURE<br><b>R. S. Fisher</b> M. O.   |  |  | 23B. ADDRESS<br><b>4940 Eastern Ave.</b>  |  |  |
| 23C. DATE SIGNED<br><b>7-2-50</b>   |  |  | 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  |
| 24B. DATE<br><b>7/3/50</b>  |  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>MOUNT CARMEL</b>   |  |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b>  |  |  | 25. FUNERAL DIRECTOR<br><b>Wm. Cook &amp; Co. 9217 St. Paul St.</b>   |  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>3-1950</b>   |  |  | REGISTRAR'S SIGNATURE<br><b>William Williams, M.D.</b>  |  |  |
| VS 150  |  |  | To be approved by the Medical Examiner<br><b>93D</b>  |  |  |

Patient was mentally confused due to senile  
brain degeneration and continued to get  
out of bed against orders. On one occasion  
while getting out of bed he fell and  
broke his femur - Fall was from bed  
floor.

C-100 5809

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

X 58 5809

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Myrtle Nettie Cope

2. DATE  
OF  
DEATH

7/2/50.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence  
A. STATE B. COUNTY Before admission)

Md.

D.C.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or  
location)

South Balto. Gen'l Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give  
township)

Glenburnie - Rural

D. STREET ADDRESS (If rural, give location)

Route 2 Box 494 5200

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

4/5/1890

9. AGE (In years  
last birthday)

55

10. Under 1 Year  
Months; Days11. Under 24 Hours  
Hours; Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

Own Home

13. FATHER'S NAME

Joe Sims

11. BIRTHPLACE (State or foreign country)

Oklahoma

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Martha Blue

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Robt. J. Cope Bx 494 Route 2 Glenburnie  
D.C. Md.

18. 260X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Posterior Coronary Occlusion

INTERVAL BETWEEN  
ONSET AND DEATH

One week

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Hypertension arteriosclerotic

several years

DUE TO

(C)

diabetes

several years

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 17 July, 1950, to 2 July, 1950, that I last saw the  
deceased alive on 2 July, 1950, and that death occurred at 5:30 a. m., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Huntington Williams, M.D.

40m Cook Inc 1217 St. Paul St.

JUL 3 1950

61

CERTIFICATE OF DEATH

State of New York

County of ...

City of ...

On the ... day of ...

at the age of ...

years, ...

... died ...

at ...

... cause ...

... after ...

... hours ...

... minutes ...

... seconds ...

... of ...

... of ...

... of ...

... of ...

... of ...

P-150  
50

5810

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5810

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Arlie P Pippin

2. DATE  
OF  
DEATH

June 30, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

3025 Windsor Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

3108 Walbrook Avenue

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

Yrs.  
Mos.  
Days

Life

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Saleslady Retired

10B. KIND OF BUSINESS OR INDUSTRY

Department Store

8. DATE OF BIRTH

October 13, 1886

9. AGE (In years last birthday)

63

11 Under 1 Year Months Days

11 Under 24 Hours Hours Min.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Daniel L. Holden

14. MOTHER'S MAIDEN NAME

Martha Pentz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
I. Pentz Pippin 112 Linwood Avenue

18. 491X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Bronch pneumonia

INTERVAL BETWEEN ONSET AND DEATH

1 day

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO  
(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Senile psychosis

1 year

19A. DATE OF OPERATION

NONE

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 24, 1950, to June 30, 1950, that I last saw the deceased alive on June 30, 1950, and that death occurred at 7:30 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Abraham B. Hurwitz

M. D.

23B. ADDRESS

3048 W. North Ave.

23C. DATE SIGNED

July 1, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

July 3, 1950

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge Cemetery

24D. LOCATION (City, town or county) (State)

Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Wm. Cook Inc. 1217 St. Paul St.

JUL 3 1950

107



Windsor Rest Home

3025 Windsor Ave.

E-2653

5811

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5811

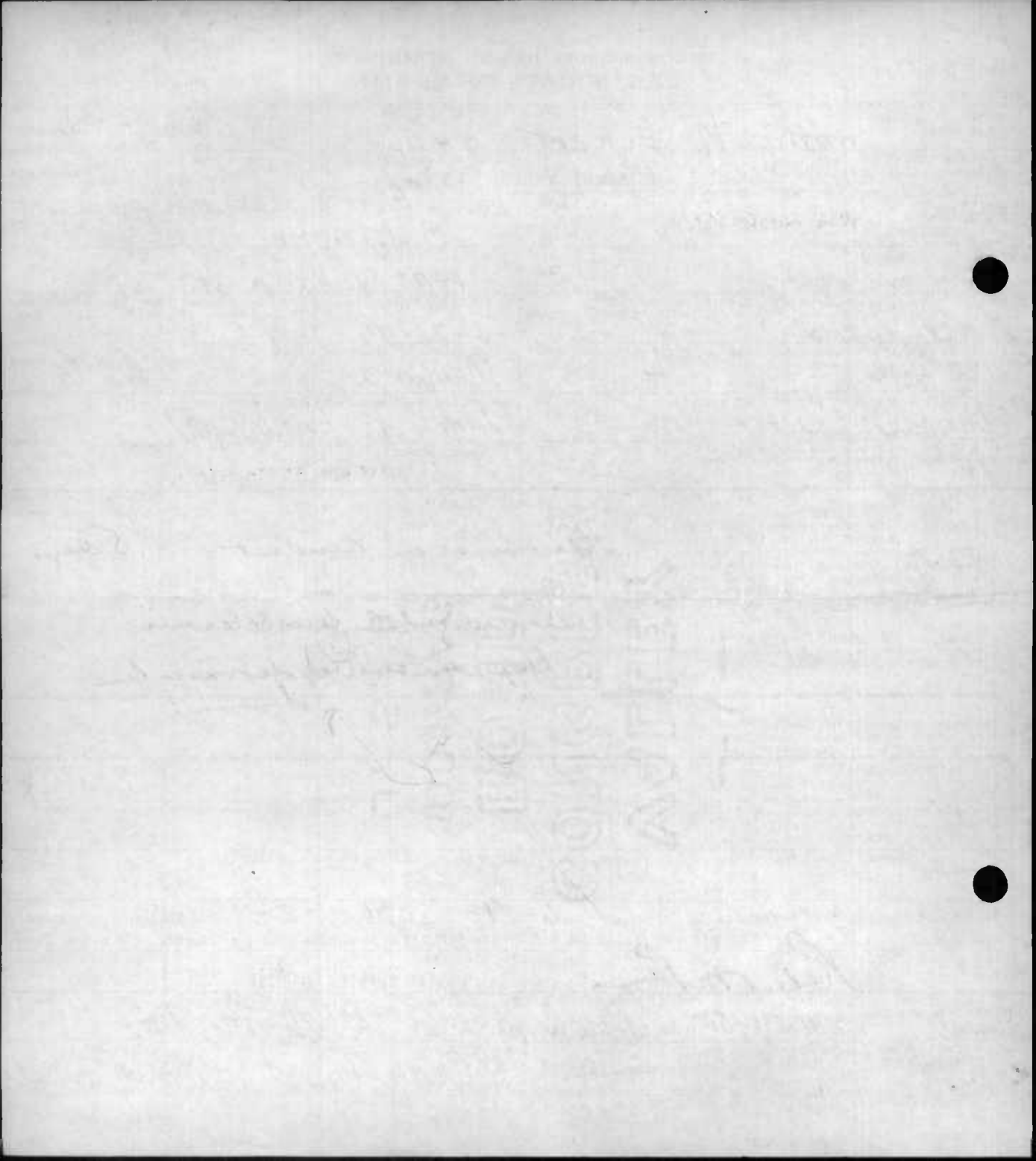
Registered No.

|   |  |  |  |
|---|--|--|--|
| BIRTH NO.   |  | 2. DATE OF DEATH<br>JUL 2 - 1950   |  |
| 1. NAME OF DECEASED<br>(Type or Print)<br>Hattie M. Eckert.   |  | 5-42647  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE<br>Md. |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>JOHNS HOPKINS HOSPITAL   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 13-08          |  |
| D. STREET ADDRESS (If rural, give location)<br>1402 Yeager St.  |  | E. DATE OF BIRTH<br>6-21-76  |  |
| F. AGE (in years last birthday)<br>74   |  | G. Under 1 Year<br>Months: Days: Hours: Min.   |  |
| H. Under 24 Hours<br>Months: Days: Hours: Min.  |  | I. BIRTHPLACE (State or foreign country)<br>Maryland   |  |
| J. CITIZEN OF WHAT COUNTRY?<br>U.S.C.   |  | K. MOTHER'S MAIDEN NAME<br>Mary F. Santmyer  |  |
| L. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br>No   |  | M. SOCIAL SECURITY NO.   |  |
| N. INFORMANT<br>JOHNS HOPKINS HOSPITAL  |  | O. ADDRESS   |  |
| 18. 443X<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br>(A) Cerebrovascular accident<br>DUE TO<br>(B) Generalized arteriosclerosis<br>DUE TO<br>(C) Hypertensive endoarteriosclerosis<br>INTERVAL BETWEEN ONSET AND DEATH<br>5 days |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |  |  |
| 19A. DATE OF OPERATION<br>0   |  | 19B. MAJOR FINDINGS OF OPERATION   |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                 |  |
| 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |  | 21D. TIME (Month) (Day) (Year) (Hour)  |  |
| 21E. INJURY OCCURRED<br>WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from 6-29-1950 to 7-2-1950 that I last saw the deceased alive on 7-2-1950, and that death occurred at 4:50 A.M., from the causes and on the date stated above.  |  |  |  |
| 23A. SIGNATURE<br>Robert M. [Signature]<br>M.D.   |  | 23B. ADDRESS<br>JOHNS HOPKINS HOSPITAL   |  |
| 23C. DATE SIGNED  |  |  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 24B. DATE<br>July 5-1950   |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br>St. Mary's Hampden  |  | 24D. LOCATION (City, town or county) (State)<br>Baltimore, Md.   |  |
| 25. FUNERAL DIRECTOR<br>Burgess Funeral Home  |  | ADDRESS<br>3634 Falls Road   |  |

MEDICAL CERTIFICATION

DATE RECEIVED BY LOCAL HEALTH DEPT.  
JUL 3-1950

93D



B-650  
50 5812BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5812  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

BLANCHE MAY BROWN

2. DATE  
OF  
DEATH

7-2-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Union Memorial Hospital

C. Length of stay in Baltimore

Lifetime

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

-

13. FATHER'S NAME

Joseph Vogt

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL  
SECURITY NO.

8. DATE OF BIRTH

May 29, 1879

9. AGE (In years  
last birthday)

71

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

14. MOTHER'S M maiden name

Maitha Sanderan

17. INFORMANT

ADDRESS

Mrs. Rita Chapman 4323 Falls Road

18. 443X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Cerebro-vascular accident

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Hypertensive Cardio-Vascular Disease

DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)

INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-2, 1950, to 7-2, 1950, that I last saw the deceased alive on 7-2-50, and that death occurred at 1:45 m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION,  
OR REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 2-1950

JUL 3-1950 7708)

93D

CERTIFICATE OF DEATH

WILLIAM L. ELLIS, JR.

1

COPIES OF  
THE  
DEATH  
CERTIFICATE  
WILLIAM L. ELLIS, JR.

F-460

50 5813

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5813

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

William F. Fowler

2. DATE  
OF  
DEATH

July 2, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

929 Webb Court

C. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Married10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Carpenter (Retired) Morton Sign Co.

10B. KIND OF BUSINESS OR  
INDUSTRY

13. FATHER'S NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no or unknown)

No

(If yes, give war or dates of service)

No

16. SOCIAL

SECURITY NO.

212.07.1503

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

929 Webb Court

8. DATE OF BIRTH

7/25/1883

9. AGE (In years  
last birthday)

66

11 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

14. MOTHER'S MAIDEN NAME

Unknown

17. INFORMANT

ADDRESS

Mrs. Catherine Fowler 929 Webb Ct.

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Cerebral Hemorrhage  
DUE TO

60 hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Hypertensive (Cardio-  
vascular Disease  
DUE TO

10 years

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JANUARY 1, 1949, to JULY 2, 1950, that I last saw the  
deceased alive on JULY 2, 1950, and that death occurred at 2 A. M., from the causes and on the date stated above.

23A. SIGNATURE

Melvin N. Bradley

M. D.

23B. ADDRESS

2030 W. Fayette St

23C. DATE SIGNED

7/2/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/5/50

24C. NAME OF CEMETERY OR CREMATORY

Western

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

ADDRESS

John T. Stansbury 2700 Edmondson Av.

JUL 3-1950

JUL 3-1950

51082

937

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

State of New York

County of ...

City of ...

Decedent's Name ...

Age ...

Sex ...

Marital Status ...

Occupation ...

Signature ...

Witnesses ...

No.

Handwritten signature or mark.

7

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Printed text at the bottom.

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F-260

50 5814

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5814

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES FISHER

2. DATE  
OF  
DEATH

7-1-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

ST. JOSEPH'S HOSP.

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

W?

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

BOILER MAKER

10B. KIND OF BUSINESS OR  
INDUSTRY

?

13. FATHER'S NAME

LEONARD FISHER

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

-

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

MARYLAND

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE

10-01

D. STREET ADDRESS (If rural, give location)

LITTLE SISTERS OF POOR

8. DATE OF BIRTH

11/16/1862

9. AGE (In years  
last birthday)

88

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

USA

14. MOTHER'S MAIDEN NAME

JESSE YAEGER

17. INFORMANT

ADDRESS

AUSTIN P. FISHER-667 N. MADERIA

18. 610X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) ACUTE URINARY RETENTION

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) BENIGN PROSTATIC HYPERTROPHY

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) GENERAL ARTERIOSCLEROSIS

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-23, 1950, to 7-1, 1950 that I last saw the  
deceased alive on 6-30, 1950 and that death occurred at 4:29 a. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

1400 N. Caroline St

7-1-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

BURIAL

7/3/50

MOUNTAIN CHURCH

KINGSVILLE MD

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 3 - 1950

Wm. J. Williams, M.D.

Wm. J. Williams, M.D.

2008  
Belmont St

137a

MEDICAL CERTIFICATION

STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL  
IN SENATE

1911

W. W. W.

REPORT OF THE  
COMMISSIONER OF THE  
LAND OFFICE  
FOR THE YEAR  
1910

1911

0

H-416  
50 5815

50 5815

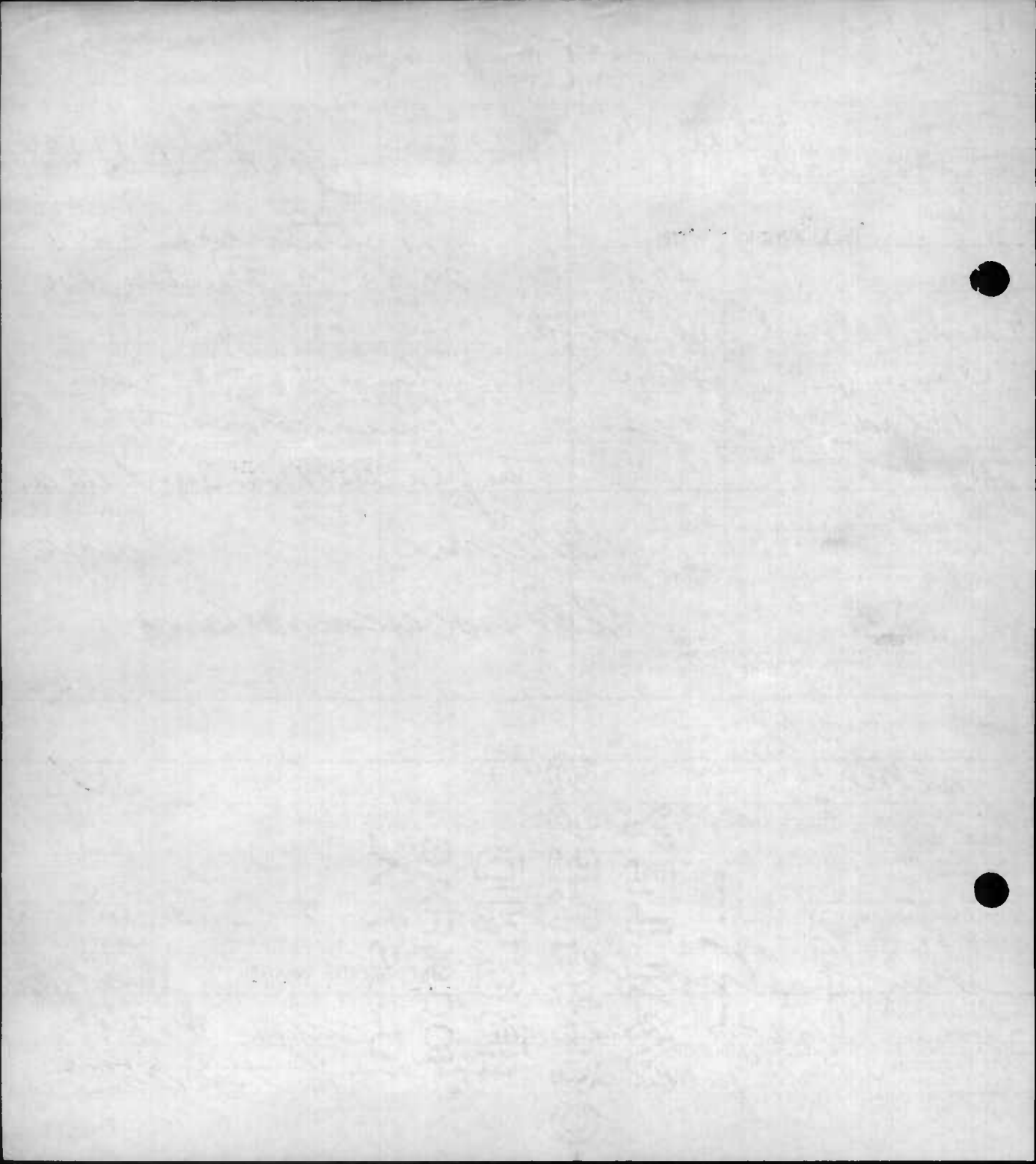
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

|   |                                    |  |                                       |   |   |
|---|------------------------------------|--|---------------------------------------|---|---|
| BIRTH NO.   |                                    | 1. NAME OF DECEASED<br>(Type or Print) <i>Ethel Halbrook</i>   |                                       | 2. DATE OF DEATH<br><i>July 1, 1950</i>   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>md</i> B. COUNTY <i>1</i> |                                       |   |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>JOHNS HOPKINS HOSPITAL</i>  |                                    | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 15-04</i>                         |                                       |   |   |
| C. Length of stay in Baltimore<br><i>49 yrs.</i>  |                                    | D. STREET ADDRESS (If rural, give location)<br><i>2033 N. Fulton Ave</i>   |                                       |   |   |
| 5. SEX<br><i>Female</i>   | 6. COLOR OR RACE<br><i>Colored</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Married</i>  | 8. DATE OF BIRTH<br><i>10-18-1901</i> | 9. AGE (In years last birthday)<br><i>49</i>  | 10. Under 1 Year<br>Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>   |                                    | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Home</i>   |                                       | 11. BIRTHPLACE (State or foreign country)<br><i>Baltimore, Md.</i>                                  |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><i>USA.</i>   |                                    | 13. FATHER'S NAME<br><i>Kathaniel Bargeas</i>  |                                       | 14. MOTHER'S MAIDEN NAME<br><i>Louisa Fossett</i>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>No</i>   |                                    | 16. SOCIAL SECURITY NO.  |                                       | 17. INFORMANT<br><i>Mr. John Halbrook</i> ADDRESS<br><i>JOHNS HOPKINS HOSPITAL 2033 Fulton Ave.</i> |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>171X</i>  |                                    | CAUSE OF DEATH<br>(A) <i>Uremia</i><br>DUE TO<br>(B) <i>Adenocarcinoma Cervix</i><br>DUE TO<br>(C)                             |                                       | INTERVAL BETWEEN ONSET AND DEATH<br><i>2 yrs</i>  |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |                                    |  |                                       |   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                                    |  |                                       |   |   |
| 19A. DATE OF OPERATION<br><i>none</i>   |                                    | 19B. MAJOR FINDINGS OF OPERATION   |                                       | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                 |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |                                    | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                                      |                                       | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                            |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                    | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                         |                                       | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I hereby certify that I attended the deceased from <i>6-4-</i> , 19 <i>50</i> to <i>7-1-</i> , 19 <i>50</i> , that I last saw the deceased live on <i>7-1-</i> , 19 <i>50</i> , and that death occurred at <i>10:05</i> m., from the causes and on the date stated above. |                                    |  |                                       |   |   |
| 23A. SIGNATURE<br><i>John H. Angell</i> M. D.   |                                    | 23B. ADDRESS<br><i>JOHNS HOPKINS HOSPITAL</i>  |                                       | 23C. DATE SIGNED<br><i>July 1, 1950</i>   |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   |                                    | 24B. DATE<br><i>July 5, 1950</i>   |                                       | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Arbutus Mem. Ch.</i>                                       |   |
| 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore Co. Md</i>  |                                    | 24E. FUNERAL DIRECTOR<br><i>Hollandy Funeral Home</i>  |                                       | 24F. ADDRESS<br><i>1618 N. David Hill Ave</i>   |   |
| DATE RECEIVED BY LOCAL REGISTRAR  |                                    | REGISTRAR'S SIGNATURE<br><i>Wilmington Williams, M.D.</i>  |                                       | 25. FUNERAL DIRECTOR<br><i>Hollandy Funeral Home</i>  |   |

JUL 3 - 1950

48a



AB-138572

B-260 5816

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5816  
Registered No.

BIRTH NO.

|   |                                  |   |  |  |                                  |
|---|----------------------------------|---|--|--|----------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Lorenzo Baker</b>   |                                  |   | 2. DATE OF DEATH <b>July 1-1950</b>  |  |                                  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |  |                                  |
| 5. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b><br><b>4940 Eastern Ave.</b> |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>13-03</b>                  |  |                                  |
| 6. Length of stay in Baltimore <b>12yrs.</b>  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>2526 Francis Street</b>  |  |                                  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Negro</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b> | 8. DATE OF BIRTH<br><b>March 8- 1920</b>   | 9. AGE (in years last birthday)<br><b>30</b> | 10. Under 1 Year<br>Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>   |                                  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Steel worker</b>   |  |                                  |
| 11. BIRTHPLACE (State or foreign country)<br><b>North Carolina</b>  |                                  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>  |  |                                  |
| 13. FATHER'S NAME<br><b>Henry Baker</b> (D)   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Rockanna Carpenter</b> (D)  |  |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>Yes, no or (unknown)</b>  |                                  |   | 16. SOCIAL SECURITY NO.  |  |                                  |
| 17. INFORMANT<br><b>Baltimore City Hospitals</b>  |                                  |   | ADDRESS<br><b>Records: 4940 Eastern Ave.</b>   |  |                                  |

18. **4222** CAUSE OF DEATH

I  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Myocarditis.**

DUE TO

## ANTECEDENT CAUSES

(B)  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

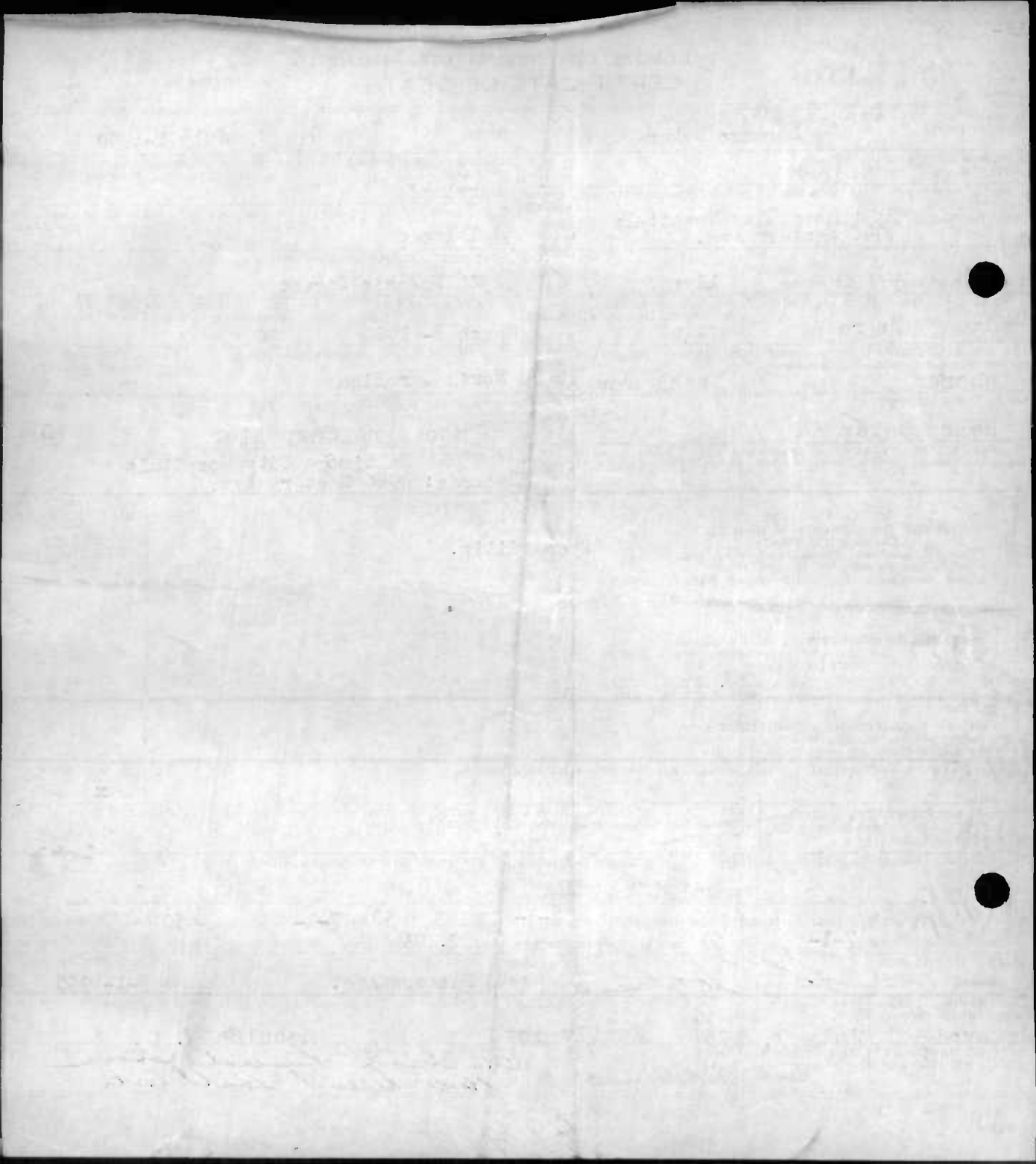
|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 19A. DATE OF OPERATION <b>7-1-1950</b>  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>6-3-</b> 19 <b>50</b> to <b>7-1-</b> 19 <b>50</b> that I last saw the deceased alive on <b>7-1-</b> 19 <b>50</b> and that death occurred at <b>7.20A.m.</b> , from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE<br><i>[Signature]</i> M. D.  |  | 23B. ADDRESS<br><b>4940 Eastern Ave.</b>  |  | 23C. DATE SIGNED<br><b>7-1-1950</b>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   |  | 24B. DATE<br><b>July 3, 1950</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Family lot</b>                             |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Zebulon N. C.</b>   |  | 24E. FUNERAL DIRECTOR<br><i>[Signature]</i>   |  | 24F. ADDRESS<br><b>1631 Druid Hill Ave</b>  |  |
| DATE RECEIVED BY LOCAL REGISTRAR  |  | REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  | 25. FUNERAL HOME<br><i>[Signature]</i>  |  |

JUL 3-1950

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93B





50 5817  
F-300BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5817  
Registered No.

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>JOHN TUTT</b>  |  |  | 2. DATE OF DEATH <b>July 1, 1950</b>   |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>University Hospital</b>                               |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>Baltimore</b><br>C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>4-02</b><br>D. STREET ADDRESS (If rural, give location) <b>725 Waesche Street</b> |  |  |
| 5. LENGTH OF STAY IN BALTIMORE   |  |  | 6. COLOR OR RACE <b>Colored</b>  |  |  |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  |  |  | 8. DATE OF BIRTH <b>Aug. 12, 1918</b>  |  |  |
| 9. SEX <b>Male</b>   |  |  | 10. AGE (In years last birthday) <b>31</b>   |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b> |  |  | 11. BIRTHPLACE (State or foreign country) <b>Augusta, Ga.</b>  |  |  |
| 10B. KIND OF BUSINESS OR INDUSTRY <b>Contractors</b>   |  |  | 12. CITIZEN OF WHAT COUNTRY?   |  |  |
| 13. FATHER'S NAME <b>Willis Tutt</b>   |  |  | 14. MOTHER'S MAIDEN NAME <b>Gertrude Cobb</b>  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)    |  |  | 16. SOCIAL SECURITY NO. <b>218-01-5919</b>   |  |  |
| 17. INFORMANT <b>Mrs. Gertrude Norris, 725 Waesche St.</b>   |  |  | ADDRESS  |  |  |

|   |  |
|---|--|
| 18. <b>E981X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Bullet wound of back</b><br>DUE TO<br>CAUSE OF DEATH<br>INTERVAL BETWEEN ONSET AND DEATH |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO<br>(B)<br>(C)  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 19A. DATE OF OPERATION  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |  |
| 21A. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Street</b>         |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>George and Biddle Streets</b> |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY<br><b>July 1, 1950 5:00 A.M.</b>  |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?<br><b>Revolver shot in back</b>   |  |
| I certify that I took charge of the remains described above, held an <b>Autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> . |  |   |  |  |  |
| 23A. SIGNATURE<br><b>Stanley H. Hurlacher</b>   |  | 23B. CHIEF MEDICAL EXAMINER<br><b>Stanley H. Hurlacher</b>  |  | 23C. DATE SIGNED<br><b>July 1, 1950</b>  |  |

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> |  | 24B. DATE<br><b>July 5, 1950</b>                     |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b> |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b> |  |
| DATE RECEIVED BY LOCAL REGISTRAR                           |  | REGISTRAR'S SIGNATURE<br><b>Stanley H. Hurlacher</b> |  | 25. FUNERAL DIRECTOR<br><b>Halland Funeral Home</b>             |  | ADDRESS<br><b>1631 Druid Hill Ave.</b>                                 |  |

VS 151 JUL 3-1950 876.4 97024 166

CERTIFICATE OF DEATH

STATE OF NEW YORK

County of \_\_\_\_\_

City of \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_

\_\_\_\_\_

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REA-139155

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50 5818

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

|   |                                  |   |  |  |   |
|---|----------------------------------|---|--|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Pearline Solomon</b>  |                                  |   | 2. DATE OF DEATH <b>June 30, 1950</b>  |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |  |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTE <b>Baltimore City Hospitals</b><br><b>4940 Eastern Avenue</b> |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>22-01</b>                  |  |   |
| C. Length of stay in Baltimore <b>Life</b>  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>4 W. Henrietta Street (30)</b>   |  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Negro</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b> | 8. DATE OF BIRTH<br><b>Oct. 7, 1930</b>  | 9. AGE (In years last birthday)<br><b>19</b>   | If Under 1 Year<br>Months: Days<br>If Under 24 Hours<br>Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY                                 |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                         |   |
| 13. FATHER'S NAME<br><b>Robert Bond</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Josephine Peoples</b>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT <b>Baltimore City Hospitals</b><br><b>Records: 4940 Eastern Avenue</b> |   |

|  |                                  |
|--|----------------------------------|
| 18. <b>002X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Pulmonary Tuberculosis</b><br>DUE TO<br>(A) <b>Pulmonary Tuberculosis</b><br>(B)<br>(C)<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO<br>(B)<br>(C)<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | INTERVAL BETWEEN ONSET AND DEATH |
|--|----------------------------------|

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 19A. DATE OF OPERATION <b>7/4/1950</b>   |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I hereby certify that I attended the deceased from <b>June 23, 1950</b> , to <b>June 30, 1950</b> , that I last saw the deceased alive on <b>June 30, 1950</b> , and that death occurred at <b>10:05 A. M.</b> , from the causes and on the date stated above. |  |  |  |  |  |
| 23A. SIGNATURE <b>[Signature]</b>  |  | 23B. ADDRESS <b>4940 Eastern Avenue</b>                                  |  | 23C. DATE SIGNED   |  |

|  |   |  |   |
|--|---|--|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24B. DATE<br><b>7/4/1950</b>                | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Mount Calvary</b> | 24D. LOCATION (City, town, or county) (State)<br><b>A. A. Co., Md</b> |
| DATE RECEIVED BY LOCAL REGISTRAR                           | REGISTRAR'S SIGNATURE<br><b>[Signature]</b> | 25. FUNERAL DIRECTOR<br><b>J. P. Brown</b>                 | ADDRESS<br><b>108 W. Montgomery St</b>                                |

III 3-1950

13B

Received 7/4/1920 Mount Baldy  
C. E. Brewster  
of A. Co. Inc.  
1000

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Eugene Lester Shupe*

2. DATE  
OF  
DEATH

*July 1, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or hospital or location)  
INSTITUTION

*University Hospital (DOA)*

C. Length of stay in Baltimore

*25 yrs.*

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

*948 W. Lombard St.*

5. SEX

*Male*

6. COLOR OR RACE

*White*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*Married*

8. DATE OF BIRTH

*June 4, 1917*

9. AGE (In years last birthday)

*33*

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Truck driver*

10B. KIND OF BUSINESS OR INDUSTRY

*Oil Truck*

11. BIRTHPLACE (State or foreign country)

*Edwards Cross Roads, North Carolina*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*Edward S. Shupe*

14. MOTHER'S MAIDEN NAME

*May Shumake*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

*No*

16. SOCIAL SECURITY NO.

*212-129041*

17. INFORMANT

*Minnie S. Shupe*

ADDRESS

18. *420.1*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

*Coronary Disease*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

I certify that I took charge of the remains described above, held an *Inspection* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

*Wm. H. Kammer, D. M.D.*

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

*July 1, 1950*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*July 4 - 1950*

24C. NAME OF CEMETERY OR CREMATORY

*Oak Grove Cem*

24D. LOCATION (City, town, or county)

*Frederick County, Md*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Washington Williams, Jr.*

25. FUNERAL DIRECTOR

*Shewenber Funeral Service*

MEDICAL CERTIFICATION



CLYRICITE OREDEATH

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5820  
Registered No. 177X

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland  
3920 Yolando Rd.  
(b) Street address  
(c) Hospital or institution:  
00 3920 Yolando Rd.  
(d) Length of stay in hospital or inst. (yrs., mos., or days)  
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md. (b) County  
(c) City or town Baltimore 9-01  
(If outside city or town limits, write RURAL and give town)  
(d) Street No. 3920 Yolando Rd.  
(If rural give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

**3 (a) FULL NAME**

**J. LAWRENCE HEDEMAN**

3 (b) If veteran, name war no  
3 (c) Social Security Account No. no

4. Sex male 5. Color or race white 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Rose A. Hedeman  
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 28, 1869

8. AGE: Years 80 Months Days If less than one day  
hr. min.

9. Birthplace Maryland  
(Town, county, and state)

10. Usual Occupation Clerk - Lumber Inspector

11. Industry or business Lumber

FATHER 12. Name Henry Hedeman

13. Birthplace Md.

MOTHER 14. Maiden Name Mary

15. Birthplace Md.

16 (a) Informant Mrs. Dorothy H. Champness

(b) Address 1388 Pentwood Rd.

17 (a) Burial (b) Date thereof 7/5/50

(c) Cemetery or crematory Woodlawn Cem.

Location Woodlawn, Md.

18 (a) Funeral director Wm. J. Tichner & Sons

(b) Address Balt. Md.

19 (a) Date of death 7-3-1950 (b) Registrar Huntington Williams

Address 201 W. Pennsylvania Ave Date signed 7/1/50

**MEDICAL CERTIFICATION**

20. DATE OF DEATH July 1 1950, at 12:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 12 1950, to July 1 1950, and that I last saw him alive on June 30 1950.

Immediate cause of death: *relapsing Acute Myocardial Infarction* Duration 3 mos.

Due to *Coronary Thrombosis*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. J. Tichner

Address 201 W. Pennsylvania Ave Date signed 7/1/50

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

## INSTRUCTIONS FOR MEDICAL CERTIFICATION

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### WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

### DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

### DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE

cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

### DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

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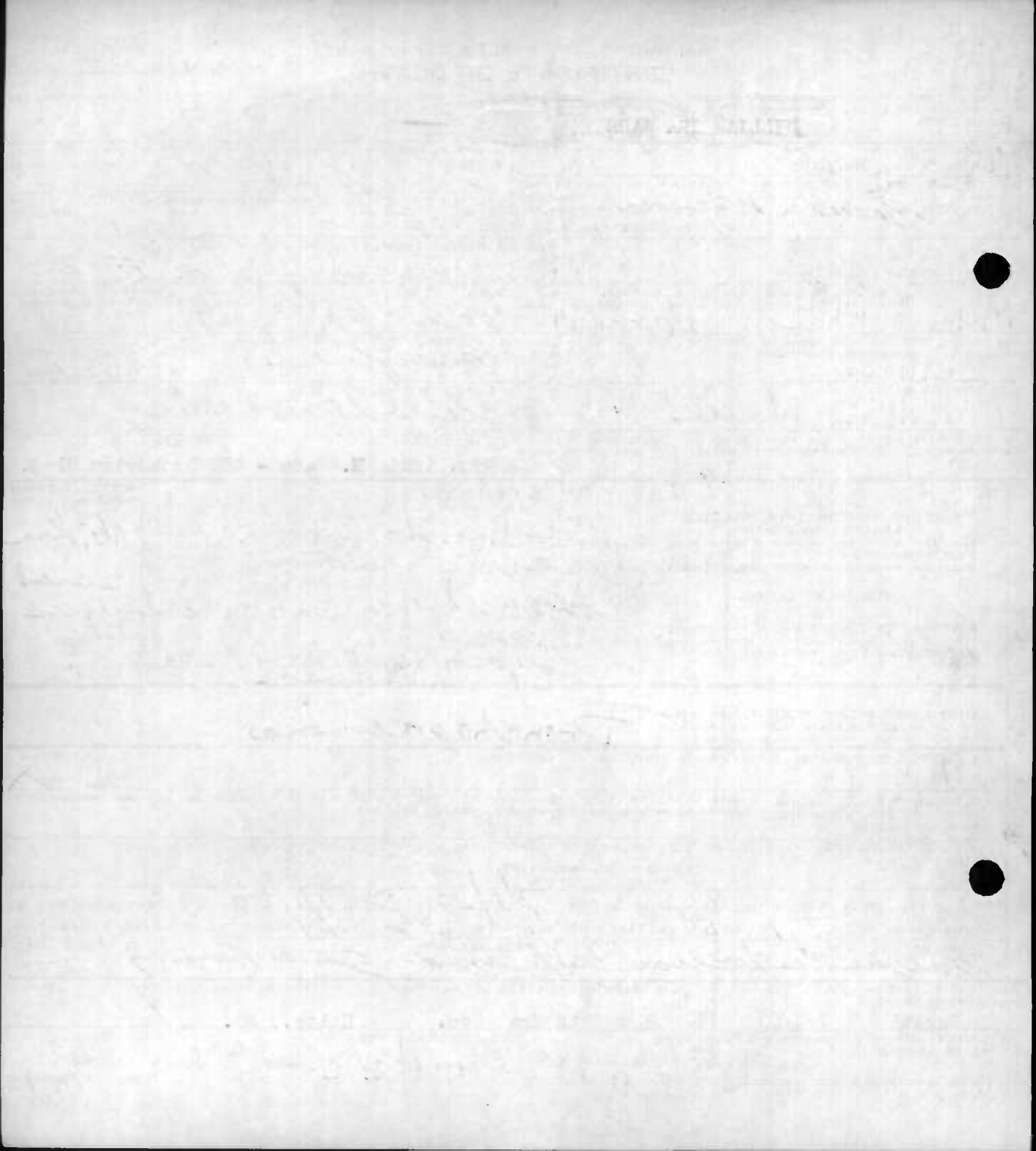
For additional discussion of this subject see **PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION** issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

W-300  
50 5821BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

X 50 5821

|  |                        |   |                          |
|--|------------------------|---|--------------------------|
| BIRTH NO.  |                        | 2. DATE OF DEATH  |                          |
| 1. NAME OF DECEASED<br>(Type or Print) WILLIAM IRA WADE  |                        | 7/1/50  |                          |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                        | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE Maryland B. COUNTY Anne Arundel |                          |
| B. FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital  |                        | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 5200                                       |                          |
| C. Length of stay in Baltimore 67 Yrs. Mos. Days   |                        | D. STREET ADDRESS (If rural, give location) 400 Broadview Ave # 25  |                          |
| 5. SEX Male  | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married   | 8. DATE OF BIRTH 6-25-83 |
| 9. AGE (In years last birthday) 67   |                        | 10. UNDER 1 Year 11. Under 24 Hours   |                          |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Father   |                        | 10B. KIND OF BUSINESS OR INDUSTRY   |                          |
| 13. FATHER'S NAME William Wade   |                        | 12. CITIZEN OF WHAT COUNTRY? USA  |                          |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO  |                        | 16. SOCIAL SECURITY NO.   |                          |
| 17. INFORMANT Mrs. Annie M. Wade - 400 Broadview Blvd.   |                        | ADDRESS   |                          |
| 18. 443X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)                      |                        | CAUSE OF DEATH  |                          |
| DUE TO (A) Cardiac failure & Cardiac asthma  |                        | INTERVAL BETWEEN ONSET AND DEATH Not known  |                          |
| DUE TO (B) Atherosclerotic cardiovascular disease  |                        | Several years   |                          |
| DUE TO (C) Hypertensive cardiovascular disease   |                        | ?   |                          |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Broncho pneumonia   |                        |   |                          |
| 19A. DATE OF OPERATION 0   |                        | 19B. MAJOR FINDINGS OF OPERATION  |                          |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                        |   |                          |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  |                        | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |                          |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                        |   |                          |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                        | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                            |                          |
| 21F. HOW DID INJURY OCCUR?   |                        |   |                          |
| 22. I hereby certify that I attended the deceased from 6/1/50, 1950, to 7/1/50, 1950, that I last saw the deceased alive on 7/1, 1950 and that death occurred at 6:27 pm., from the causes and on the date stated above. |                        |   |                          |
| 23A. SIGNATURE Margaret J. Jucius  |                        | 23B. ADDRESS M. D. Md. State Hosp.  |                          |
| 23C. DATE SIGNED 7/1/50  |                        |   |                          |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial   |                        | 24B. DATE 7/4/50  |                          |
| 24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.  |                        | 24D. LOCATION (City, town, or county) Balto., Md. (State)   |                          |
| DATE RECEIVED BY LOCAL REGISTRAR   |                        | REGISTRAR'S SIGNATURE   |                          |
| JUL 3 - 1950   |                        | T. M. J. Tichener & Sons - Balto  |                          |
| 59424  |                        | 937 Md.   |                          |



M-622  
50 5822BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5822  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

EVELYN MARKUS

2. DATE  
OF  
DEATH

June 30, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

1935 Ridgehill Ave.

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

at Home

13. FATHER'S NAME

Henry Sacks

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

no

4. USUAL RESIDENCE (Where deceased lived, If institution: residence  
before admission)

A. STATE

Md.

B. COUNTY

C. CITY OR TOWN

Baltimore

D. STREET ADDRESS (If rural, give location)

1935 Ridgehill Ave.

8. DATE OF BIRTH

April 25, 1906

9. AGE (In years  
last birthday)

44

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Mary Manion

17. INFORMANT

ADDRESS

Mr. Andrew Markus - 1935 Ridgehill Ave.

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Carcinoma of breast  
to metastasesINTERVAL BETWEEN  
ONSET AND DEATH

5 yrs.

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 30, 1950, to Jan 30, 1950, that I last saw the  
deceased alive on Jan 30, 1950, and that death occurred at 12:45 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Dr. Harry Ashman

M. D.

23B. ADDRESS

1926 North Ave

23C. DATE SIGNED

2/30/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/3/50

24C. NAME OF CEMETERY OR CREMATORY

Woodlawn Cem.

24D. LOCATION (City, town, or county)

Woodlawn, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William J. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Wm. J. Lightner - 1500 - Balt

JUL 31 1950

50

md.



WILLIAM H. HARRIS

WILLIAM H. HARRIS



F-120 5823

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5823  
Registered No.

|  |                              |   |  |   |  |   |  |                                  |                                   |
|--|------------------------------|---|--|---|--|---|--|----------------------------------|-----------------------------------|
| BIRTH NO.  |                              |   | 1. NAME OF DECEASED<br>(Type or Print) <b>MINNIE FABIG</b>   |   |  | 2. DATE OF DEATH <b>7-1-50</b>                              |  |                                  |                                   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                              |   | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <b>MD</b><br>B. COUNTY |   |  |   |  |                                  |                                   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>SOUTH BALTIMORE GEN. HOSP</b> |                              |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTIMORE 25-06</b>                   |   |  |   |  |                                  |                                   |
| C. Length of stay in Baltimore<br>Yrs. Mos. Days   |                              |   | D. STREET ADDRESS (If rural, give location)<br><b>3733 LEO ST.</b>   |   |  |   |  |                                  |                                   |
| 5. SEX<br><b>F.</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>MARRIED</b> |  | 8. DATE OF BIRTH<br><b>FEB. 22 1879</b> |  | 9. AGE (In years last birthday)<br><b>71</b>                |  | 10. Under 1 Year<br>Months: Days | 11. Under 24 Hours<br>Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>          |                              |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b>   |   |  | 11. BIRTHPLACE (State or foreign country)<br><b>GERMANY</b> |  | 12. CITIZEN OF WHAT COUNTRY?     |                                   |
| 13. FATHER'S NAME<br><b>WEISNER</b>  |                              |   | 14. MOTHER'S MAIDEN NAME<br><b>UNKNOWN</b>   |   |  |   |  |                                  |                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                 |                              |   | 16. SOCIAL SECURITY NO.  |   |  | 17. INFORMANT ADDRESS                                       |  |                                  |                                   |

|  |  |  |  |  |
|--|--|--|--|--|
| 18. <b>443X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) |  | CAUSE OF DEATH<br>(A) <b>Cerebral Hemorrhage</b><br>DUE TO |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>98 hrs</b><br><br><b>1 yr</b><br><br><b>9 yrs</b> |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  | (B) <b>Hypertensive Arteriosclerosis</b><br>DUE TO         |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  | (C) <b>Diabetes Mellitus</b>                               |  |  |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 19A. DATE OF OPERATION <b>0</b>              |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |

22. I hereby certify that I attended the deceased from **28 June 1950**, to **1 July 1950** that I last saw the deceased alive on **1 July 1950**, and that death occurred at **12:30 p.m.**, from the causes and on the date stated above.

|                                      |  |  |  |                                   |  |
|--------------------------------------|--|--|--|-----------------------------------|--|
| 23A. SIGNATURE<br><b>W. B. Fabig</b> |  | 23B. ADDRESS<br>M. D. <b>50 Baltimore Gen Hosp</b> |  | 23C. DATE SIGNED<br><b>7-1-50</b> |  |
|--------------------------------------|--|--|--|-----------------------------------|--|

|  |  |                            |  |  |  |   |  |
|--|--|----------------------------|--|--|--|---|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b> |  | 24B. DATE<br><b>7/5/50</b> |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRIDGE GEN</b> |  | 24D. LOCATION (City, town, or county) (State)<br><b>WASHINGTON BLVD</b> |  |
|--|--|----------------------------|--|--|--|---|--|

|   |  |   |  |   |  |                                     |  |
|---|--|---|--|---|--|-------------------------------------|--|
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 3 - 1950</b> |  | REGISTRAR'S SIGNATURE<br><b>W. B. Fabig</b> |  | 25. FUNERAL DIRECTOR<br><b>JOHN F. DEURY, INC</b> |  | ADDRESS<br><b>715 LIGHT ST - 30</b> |  |
|---|--|---|--|---|--|-------------------------------------|--|

CERTIFICATE OF DEATH

John J. Thompson

John J. Thompson

John J. Thompson

5-536

50 5824

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5824  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARY G. SANDERS

2. DATE  
OF  
DEATH

7/2/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

129 W. CLEMENT ST

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)  
A. STATE

MD

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

23-01

D. STREET ADDRESS (If rural, give location)

129 W. CLEMENT ST.

C. Length of stay in Baltimore

LIFE

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

- 1871

9. AGE (in years  
last birthday)

79

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

HOUSE WIFE

10B. KIND OF BUSINESS OR  
INDUSTRY

HOME

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

— KRUG.

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

GEORGE E. SANDERS 2816 HARVARD AVE

18. 443X1 CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Cerebral Thrombosis, left 7 days.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) DUE TO  
(C)Arteriosclerotic Hypertension ?  
Coronary Vascular Disease

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 26, 1950, to July 2, 1950, that I last saw the  
deceased alive on July 2, 1950, and that death occurred at 5:40 AM, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

John P. Bullock Jr.

M. O.

1227 Wash Blvd

7-3-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

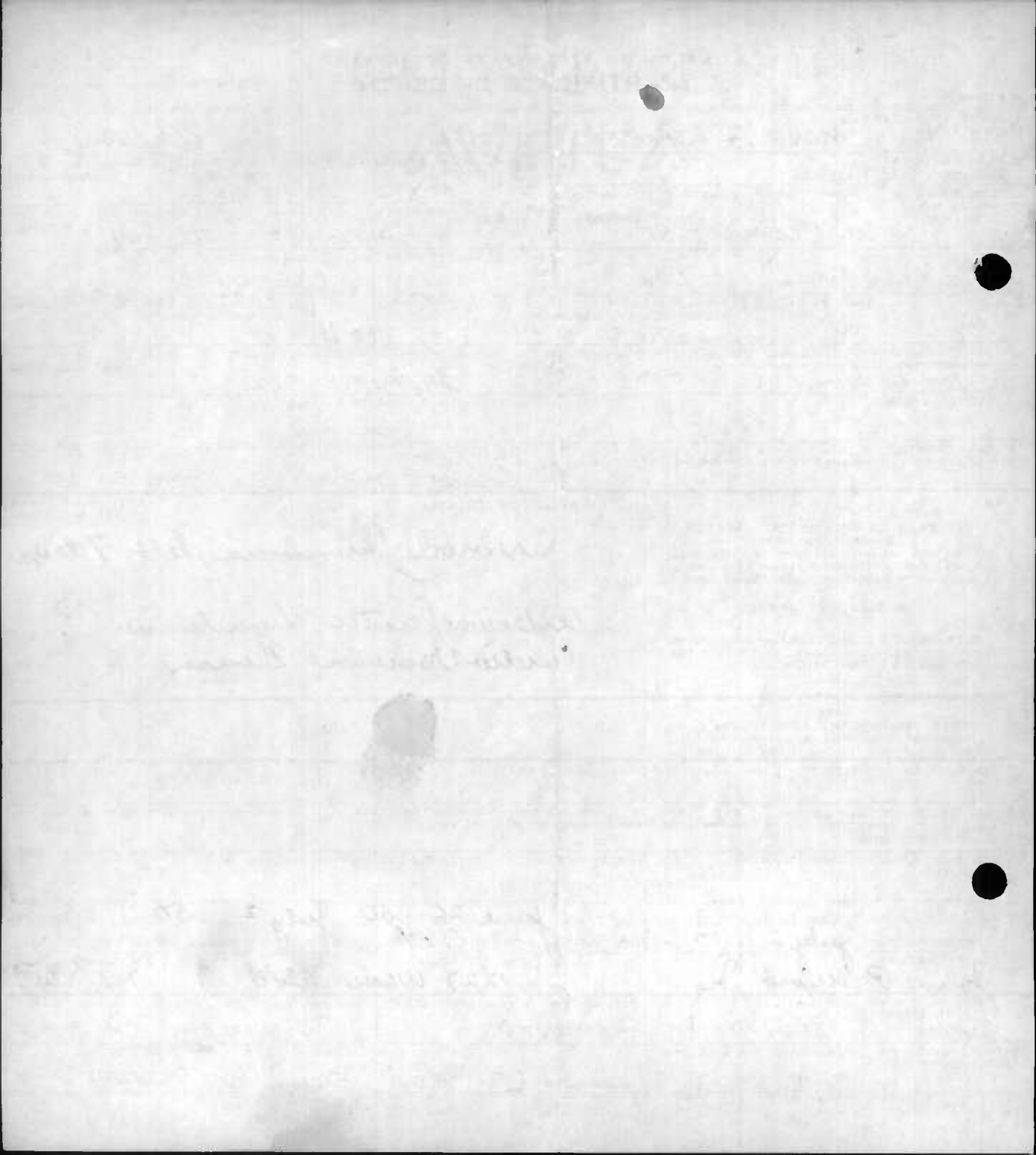
Huntington Williams, M.D.

JOHN F. DENNY, INC 715 LIGHT ST-30

JUL 3 1950

93D

MEDICAL CERTIFICATION



50 5825

50 5825

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CLARA E Bradley

2. DATE  
OF  
DEATH

July 1, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

1267 William St.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
A. STATE B. COUNTY before admission)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 24-03

D. STREET ADDRESS (If rural, give location)

1267 William St.

5. SEX

Female White

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Oct. 24, 1869

9. AGE (in years  
last birthday)

80

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR  
INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Cambridge, Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

James V. Bradley 1267 William

18. 4 10 X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

1 yr

2 yr

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 5-1949, 1950, to July 1, 1950, that I last saw the  
deceased alive on July 1, 1950, and that death occurred at 10 A. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 3-1950

John F. Denny INC, 715 LIGHT ST.

92 B

MEDICAL CERTIFICATION



10:30 - 12:30

1279 VILLIARD ST.

W-420  
50 5826BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5826  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mary A. Welsh

2. DATE  
OF  
DEATH

7/2/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

St. Joseph's Aged Home

C. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

19-03

D. STREET ADDRESS (If rural, give location)

108 Calhoun St.

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

8/31/1875

9. AGE (In years  
last birthday)

74

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

House work

10B. KIND OF BUSINESS OR  
INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William Welsh

14. MOTHER'S MAIDEN NAME

Jane Crawley

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Anna E. Murphy

ADDRESS

1251 W. Cross St.

18. 151X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Carcinoma Stomach

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) DUE TO  
(C) DUE TO

(X ray diagnosis

Ben Secours)

no operation done)

INTERVAL BETWEEN  
ONSET AND DEATH

?

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

22. TIME (Month) (Day) (Year) (Hour)  
INJURY

22E. INJURY OCCURRED

22F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from 7/2/50, 19, to 7/2/50, 19, that I last saw the  
deceased alive on 7/2/50, 19, and that death occurred at 8:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Sigmund B. Nowak

M. D.

23B. ADDRESS

408 S. Patt. Pk. (m)

23C. DATE SIGNED

7/3/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/5/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Cem

24D. LOCATION (City, town, or county)

4300 Old Frederick Rd.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams

25. FUNERAL DIRECTOR

John J. Cavanaugh

ADDRESS

7 Solleys

46 B St.

JUL 3 1950

104

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C-600  
50 5827BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5827

|  |                              |  |                                 |   |                                  |
|--|------------------------------|--|---------------------------------|---|----------------------------------|
| BIRTH NO.  |                              | 1. NAME OF DECEASED<br>(Type or Print) <i>Robert P. Carr</i>   |                                 | 2. DATE OF DEATH <i>July 2, 1950</i>  |                                  |
| 3. PLACE OF DEATH:<br>a. Baltimore City, Maryland  |                              | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>a. STATE <i>MD.</i><br>b. COUNTY <i>12-03</i> |                                 |   |                                  |
| b. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>University Hospital</i>  |                              | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>BALTO.</i>  |                                 |   |                                  |
| c. Length of stay in Baltimore   |                              | d. STREET ADDRESS (If rural, give location)<br><i>2458 GREENMOUNT AVE.</i>   |                                 |   |                                  |
| 5. SEX<br><i>M</i>   | 6. COLOR OR RACE<br><i>W</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Married</i>  | 8. DATE OF BIRTH<br><i>1877</i> | 9. AGE (In years last birthday)<br><i>73</i>  | 10. Under 1 Year<br>Months: Days |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>MEAT SHOKER</i>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>SWIFT &amp; CO.</i>  |                                 | 11. BIRTHPLACE (State or foreign country)<br><i>IRELAND.</i>                        |                                  |
| 13. FATHER'S NAME<br><i>PAT. CARR.</i>   |                              | 14. MOTHER'S MAIDEN NAME<br><i>NORA O'ROURKE</i>   |                                 |   |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><i>NO</i>   |                              | 16. SOCIAL SECURITY NO.<br><i>NONE.</i>  |                                 | 17. INFORMANT ADDRESS<br><i>MRS. ROSE CARR - 2458 GREENMOUNT AVE.</i>               |                                  |
| 18. <i>260X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Diabetes mellitus</i>               |                              | CAUSE OF DEATH<br>(A) <i>Diabetes mellitus</i><br>DUE TO   |                                 | INTERVAL BETWEEN ONSET AND DEATH<br><i>6 yrs.</i>                                   |                                  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B) <i>Gangrene, right leg. Partial intestinal obstruction</i>   |                              | (C)  |                                 |   |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                              |  |                                 |   |                                  |
| 19a. DATE OF OPERATION<br><i>None</i>  |                              | 19b. MAJOR FINDINGS OF OPERATION<br><i>abstruction</i>   |                                 | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                  |
| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)<br><i>None</i>  |                              | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  |                                 | 21c. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)         |                                  |
| 21d. TIME (Month) (Day) (Year) (Hour)<br>INJURY  |                              | 21e. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                              |                                 | 21f. HOW DID INJURY OCCUR?  |                                  |
| 22. I hereby certify that I attended the deceased from <i>July 1, 1950</i> , to <i>July 2, 1950</i> , that I last saw the deceased alive on <i>July 2, 1950</i> , and that death occurred at <i>10:00 m.</i> , from the causes and on the date stated above. |                              |  |                                 |   |                                  |
| 23a. SIGNATURE<br><i>Raymond Bradshaw, Jr.</i>   |                              | 23b. ADDRESS<br><i>University Hospital</i>   |                                 | 23c. DATE SIGNED<br><i>July 2, 1950</i>   |                                  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>BURIAL -</i>   |                              | 24b. DATE<br><i>7-5-50.</i>  |                                 | 24c. NAME OF CEMETERY OR CREMATORY<br><i>CATHEDRAL - CEM. -</i>                     |                                  |
| 24d. LOCATION (City, town, county) (State)<br><i>CITY -</i>  |                              | 24e. DATE RECEIVED BY LOCAL REGISTRAR  |                                 | 24f. REGISTRAR'S SIGNATURE<br><i>Wilmington Williams, M.D.</i>                      |                                  |
| 24g. DATE RECEIVED BY LOCAL REGISTRAR<br><i>VS 1950</i>  |                              | 24h. REGISTRAR'S SIGNATURE<br><i>Wilmington Williams, M.D.</i>   |                                 | 24i. FUNERAL DIRECTOR ADDRESS<br><i>Thurfield &amp; Son</i>                         |                                  |
| 24j. <i>69040</i>  |                              |  |                                 |   |                                  |

MEDICAL CERTIFICATION

JL 3-1950  
VS 195069040  
Thurfield & Son  
61

2458

R-560

50 5828

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5828  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Mary R. Roemer

2. DATE  
OF  
DEATH

July 1, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL, and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1008 Poplar Grove St.,

B. FULL NAME OF (If not in hospital or institution, give street address or location)

1008 Poplar Grove St.

C. Length of stay in Baltimore

68--Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Mar. 12, 1857

9. AGE (In years last birthday)

93

If Under 1 Year

Months

Days

If Under 24 Hours

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

At Home

10B. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Lawrence Heineman

14. MOTHER'S MAIDEN NAME

Elizabeth Sipple

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

ADDRESS

Miss Louise Roemer 1008 Poplar Grove St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

INJURY

WHILE AT ☐ NOT WHILE ☒  
WORK AT WORK

22. I hereby certify that I attended the deceased from May 1, 1950, to July 1, 1950, that I last saw the deceased alive on July 1, 1950 and that death occurred at 6:00 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

7-4-1950

Western

Baltimore,

Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 3-1950

G. Howard Strong 3207 W. North Ave.,

94a



WV  
DEPT. OF HEALTH & HUMAN SERVICES  
OFFICE OF THE ATTORNEY GENERAL

STATE OF WEST VIRGINIA

IN SENATE

1900

1900

1900

1900

*[Handwritten signature]*  
*[Handwritten signature]*  
*[Handwritten signature]*

1900

5-324  
55 5829BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5829

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Jacob Stickel

2. DATE  
OF  
DEATH

July 2, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Balto

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

University Hospital

Yrs.  
Mos.  
Days4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE Md

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Balto 21-01

D. STREET ADDRESS (If rural, give location)

714 Carroll St

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Sept 8-1873

9. AGE (In years  
last birthday)

76

If Under 1 Year  
Months Days Hours Min.

2 21

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Furnisher

10B. KIND OF BUSINESS OR  
INDUSTRY

Furniture Business

13. FATHER'S NAME

Jacob Stickel

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

Miss H. Rund Sr 1202 Cleveland St

ADDRESS

18. 420.1

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Coronary Disease

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Wm. H. Kammer Jr.

M.D.

23B. CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☐  
MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED

July 2, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

7/4/50

24C. NAME OF CEMETERY OR CREMATORY

London Cemetery

24D. LOCATION (City, town, or county)

Fried Ave.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Geo Leimbach

ADDRESS

Lynchburg St

CLERK OF THE COURT

STATE OF NEW YORK

J-525  
50 5830

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5830

|   |                               |  |                                       |   |  |
|---|-------------------------------|--|---------------------------------------|---|--|
| BIRTH NO.   |                               | 1. NAME OF DECEASED<br>(Type or Print) <b>JOHNSON, WILLIAM</b>   |                                       | 2. DATE OF DEATH <b>6/30/50</b>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                               | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>md.</b> B. COUNTY |                                       |   |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident</b>  |                               | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 17-02</b>                    |                                       |   |  |
| C. Length of stay in Baltimore  |                               | D. STREET ADDRESS (If rural, give location) <b>610 W. Lanvale</b>  |                                       |   |  |
| 5. SEX <b>M</b>   | 6. COLOR OR RACE <b>Negro</b> | 7. SINGLE (MARRIED) WIDOWED, DIVORCED (Specify)  | 8. DATE OF BIRTH <b>Nov. 28, 1897</b> | 9. AGE (In years last birthday) <b>52</b>   | H Under 1 Year Months: Days H Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>  |                               | 10B. KIND OF BUSINESS OR INDUSTRY <b>Construction Work</b>   |                                       | 11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>                         |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |                               | 13. FATHER'S NAME <b>Milton Johnson</b>  |                                       | 14. MOTHER'S MAIDEN NAME <b>Mary</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>   |                               | 16. SOCIAL SECURITY NO.  |                                       | 17. INFORMANT <b>Georgiana Johnson</b> ADDRESS <b>610 W Lanvale St</b>              |  |
| 18. <b>J92X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Ch. Glomerulonephritis</b><br>DUE TO<br><b>Uremia</b><br><b>Pleurisy</b> |                               | CAUSE OF DEATH   |                                       | INTERVAL BETWEEN ONSET AND DEATH  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                    |                               |  |                                       |   |  |
| 19A. DATE OF OPERATION <b>0</b>   |                               | 19B. MAJOR FINDINGS OF OPERATION   |                                       | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                               | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                              |                                       | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |                               | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>              |                                       | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>6/26</b> , 19 <b>50</b> , to <b>6/30</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>6/29</b> , 19 <b>50</b> , and that death occurred at <b>5 A.m.</b> , from the causes and on the date stated above.                   |                               |  |                                       |   |  |
| 23A. SIGNATURE <b>John H. Holmes III</b> M. D.  |                               | 23B. ADDRESS <b>Provident Hosp.</b>  |                                       | 23C. DATE SIGNED <b>6/30/50</b>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 24B. DATE <b>7-3-1950</b>  |                                       | 24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem</b>                            |  |
| 24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>   |                               | 24E. FUNERAL DIRECTOR <b>Mrs. Kate R. Williams</b>   |                                       | 24F. ADDRESS <b>322 N Schroeder St</b>  |  |

MEDICAL CERTIFICATION

98449

131B

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

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B-152,  
50 5831BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5831  
Registered No.

|   |                                    |  |   |  |   |
|---|------------------------------------|--|---|--|---|
| BIRTH NO.   |                                    | 1. NAME OF DECEASED<br>(Type or Print) <b>JAMES BIBBINS</b>  |   | 2. DATE OF DEATH <b>June 27, 1950</b>                                    |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY   |   |  |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>Baltimore City Hospital</b>  |                                    | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 17-01</b>   |   |  |   |
| C. Length of stay in Baltimore<br>Yrs. Mos. Days  |                                    | D. STREET ADDRESS (If rural, give location)<br><b>565 W. Biddle Street</b>   |   |  |   |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>colored</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Single</b>   | 8. DATE OF BIRTH<br><b>Feb. 18, 1907</b>                        | 9. AGE (In years last birthday)<br><b>43</b>                             | 10. Under 1 Year Months: Days   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>La borer</b>  |                                    | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>Norfolk Va.</b> |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                       |
| 13. FATHER'S NAME<br><b>Junius Bibbins</b>  |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Mary Hackney</b>  |   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>No</b>  |                                    | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br><b>Daisy Robinson</b>                                   |   |
|   |                                    |  |   | ADDRESS<br><b>809 George St</b>  |   |
| 18. <b>493X</b><br>CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>(A) Diffuse pneumonia</b><br>DUE TO<br>ANTECEDENT CAUSES<br><b>(B)</b><br>DUE TO<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>(C)</b><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                                    |  |   |  |   |
| 19A. DATE OF OPERATION  |                                    | 19B. MAJOR FINDINGS OF OPERATION   |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                    | 21B. PLACE OF INJURY (e. g., io or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>INJURY   |                                    | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that I took charge of the remains described above, held an <b>autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .   |                                    |  |   |  |   |
| 23A. SIGNATURE<br><b>Stanley H. Derlocher</b>   |                                    | 23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/> |   | 23C. DATE SIGNED<br><b>June 28, 1950</b>                                 |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                    | 24B. DATE<br><b>7-3-1950</b>   |   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Wt. Auburn Cem. Balto.</b>      |   |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 3 - 1950</b>   |                                    | REGISTRAR'S SIGNATURE<br><b>William R. Williams, M.D.</b>  |   | 25. FUNERAL DIRECTOR<br><b>Mrs. Hattie R. Williams</b>                   |   |
|   |                                    |  |   | ADDRESS<br><b>Schroeder St</b>   |   |

98649

109B



CERTIFICATE OF DEATH

WILLIAM CITY, MISSOURI, DECEMBER 1917

WILLIAM CITY, MISSOURI

18

NAME

AGE

SEX

Cause of Death

TO BE FILLED BY THE PHYSICIAN  
I hereby certify that the above is a true and correct statement of the cause of death of the person named above, as given to me by the family or other persons having knowledge of the cause of death.

WITNESSED BY THE PHYSICIAN

Signature of Physician

Signature of Registrar

F 430

50 5832

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5832  
Registered No.

|   |                  |   |  |   |  |
|---|------------------|---|--|---|--|
| BIRTH NO.   |                  | 1. NAME OF DECEASED<br>(Type or Print)  |  | 2. DATE OF DEATH                              |  |
|   |                  | Thelma Field  |  | 7/1/1950                                      |  |
| 3. PLACE OF DEATH:  |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                           |  |   |  |
| A. Baltimore City, Maryland   |                  | STATE Maryland  |  |   |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION   |                  | B. COUNTY   |  |   |  |
| 2007 Druid Hill Ave   |                  | Baltimore 14-03   |  |   |  |
| C. Length of stay in Baltimore  |                  | D. STREET ADDRESS (If rural, give location)   |  |   |  |
| 30 yrs  |                  | 2007 Druid Hill Ave   |  |   |  |
| 5. SEX  | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)   | 8. DATE OF BIRTH   | 9. AGE (In years last birthday)               | 10. CITIZEN OF WHAT COUNTRY?   |
| Female  | Col              | Married   | 7/31/1911  | 39  | U.S.A.   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                  | 10B. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (State or foreign country)                                |   | 12. CITIZEN OF WHAT COUNTRY?   |
| House Wife  |                  |   | Maryland   |   | U.S.A.   |
| 13. FATHER'S NAME   |                  | 14. MOTHER'S MAIDEN NAME  |  |   |  |
| John F. Johnson   |                  | Georganna Johnson   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)   |                  | 16. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS  |   |  |
|   |                  |   | William Field 2007 Druid Hill Ave  |   |  |
| 18. 334X I  |                  | CAUSE OF DEATH  |  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)                      |                  | (A) Cerebral apoplexy   |  |   | 12 hrs   |
| ANTECEDENT CAUSES   |                  | (B) Malignant hypertension  |  |   | 4 mos.   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |                  | (C)   |  |   |  |
| II  |                  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  |   |  |
| 19A. DATE OF OPERATION  |                  | 19B. MAJOR FINDINGS OF OPERATION  |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                        | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour)   |                  | 21E. INJURY OCCURRED  | 21F. HOW DID INJURY OCCUR?   |   |  |
| 21D. INJURY   |                  | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                               |  |   |  |
| 22. I hereby certify that I attended the deceased from 29-10-1949 to 7-1-1950, that I last saw the deceased alive on 7-1-1950 and that death occurred at 4:45 p.m., from the causes and on the date stated above. |                  |   |  |   |  |
| 23A. SIGNATURE  |                  | 23B. ADDRESS  |  | 23C. DATE SIGNED                              |  |
| Wm H. Sanders   |                  | 1723 Druid Hill Ave   |  | 7-2-50  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   | 24B. DATE        | 24C. NAME OF CEMETERY OR CREMATORY  |  | 24D. LOCATION (City, town, or county) (State) |  |
| Burial  | 7/3/50           | Mt Calvary Cem  |  | D.A.C. Md                                     |  |
| DATE RECEIVED BY LOCAL REGISTRAR  |                  | REGISTRAR'S SIGNATURE   |  | 25. FUNERAL DIRECTOR ADDRESS                  |  |
| JUL 3-1950  |                  | Wm H. Sanders   |  | Rayner Sanders 83a                            |  |
|   |                  |   |  | 1412 E. Preston St                            |  |



M-635  
50 5833

## CERTIFICATE CORRECTED 7-5-50

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5833

|  |                               |   |  |   |                               |
|--|-------------------------------|---|--|---|-------------------------------|
| BIRTH NO.  |                               | 1. NAME OF DECEASED<br>(Type or Print) <i>Preston John F. Martin</i>  |  | 2. DATE OF DEATH <i>7/3/50</i>                                |                               |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                               | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Md</i> B. COUNTY <i>Anne Arundel Co.</i> |  |   |                               |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <i>West Baltimore General</i>  |                               | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Emmitsburg Glen Burnie</i>                                    |  |   |                               |
| C. Length of stay in Baltimore <i>2 hours</i>  |                               | D. STREET ADDRESS (If rural, give location) <i>5200</i>   |  |   |                               |
| 5. SEX <i>Male</i>   | 6. COLOR OR RACE <i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>  | 8. DATE OF BIRTH <i>April 21, 1910</i> | 9. AGE (In years last birthday) <i>40</i>                     | 10. Under 1 Year Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanics</i> |                               | 10B. KIND OF BUSINESS OR INDUSTRY <i>General Motor Corp</i>   |  | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i>     |                               |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>   |                               | 13. FATHER'S NAME <i>William M. Martin</i>  |  | 14. MOTHER'S MAIDEN NAME <i>Mary Harner</i>                   |                               |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>                                  |                               | 16. SOCIAL SECURITY NO. <i>170-07-8648</i>  |  | 17. INFORMANT ADDRESS <i>Kathryn Martin, Glen Burnie, Md.</i> |                               |

|  |                |   |                                  |
|--|----------------|---|----------------------------------|
| 18. <i>451 X</i>   | CAUSE OF DEATH |   | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) |                | (A) <i>Dissecting aneurysm of aorta</i> | <i>1 week</i>                    |
| ANTECEDENT CAUSES  |                | (B) <i>Hypertension</i>                 |                                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |                | (C)                                     |                                  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                |   |                                  |

|  |  |  |
|--|--|--|
| 19A. DATE OF OPERATION <i>2</i>              | 19B. MAJOR FINDINGS OF OPERATION   | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)         |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |

22. I hereby certify that I attended the deceased from *7-3*, 19*50*, to *7-3*, 19*50*, that I last saw the deceased alive on *7/3*, 19*50*, and that death occurred at *2 A. m.*, from the causes and on the date stated above.

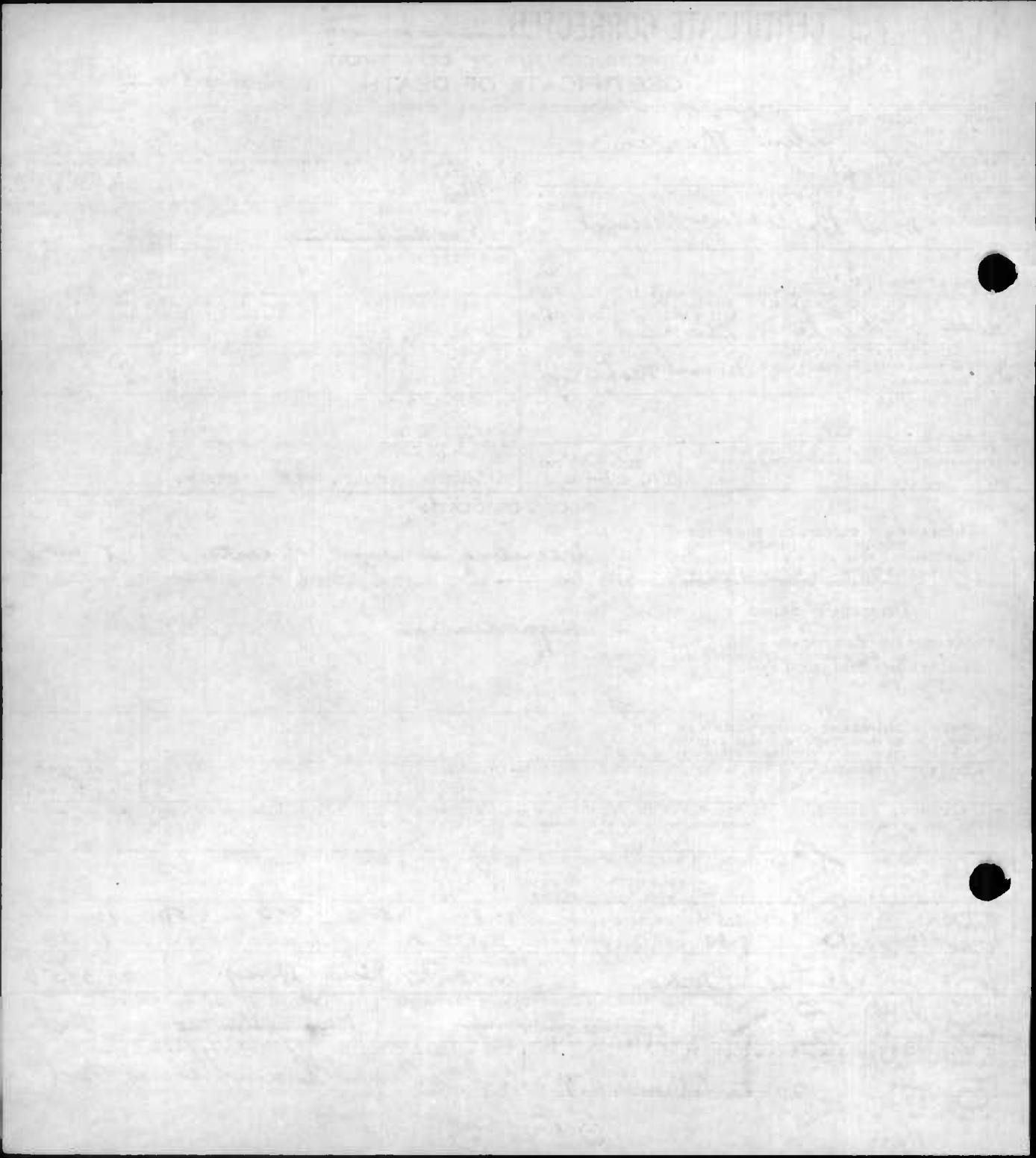
|                                    |   |                                |
|------------------------------------|---|--------------------------------|
| 23A. SIGNATURE <i>Jerome Gaber</i> | 23B. ADDRESS <i>N. Balt. Gen. Hosp.</i> | 23C. DATE SIGNED <i>7-3-50</i> |
|------------------------------------|---|--------------------------------|

|   |                            |  |   |
|---|----------------------------|--|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 24B. DATE <i>July 6-50</i> | 24C. NAME OF CEMETERY OR CREMATORY <i>Emmitsburg</i> | 24D. LOCATION (City, town, or county) (State) <i>Emmitsburg Md.</i> |
|---|----------------------------|--|---|

|                                  |  |   |                                |
|----------------------------------|--|---|--------------------------------|
| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE <i>William M. Martin</i> | 25. FUNERAL DIRECTOR <i>A. L. Allison</i> | ADDRESS <i>Emmitsburg, Md.</i> |
|----------------------------------|--|---|--------------------------------|

55035

307



W-400  
50 5834BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5834

Registered No.

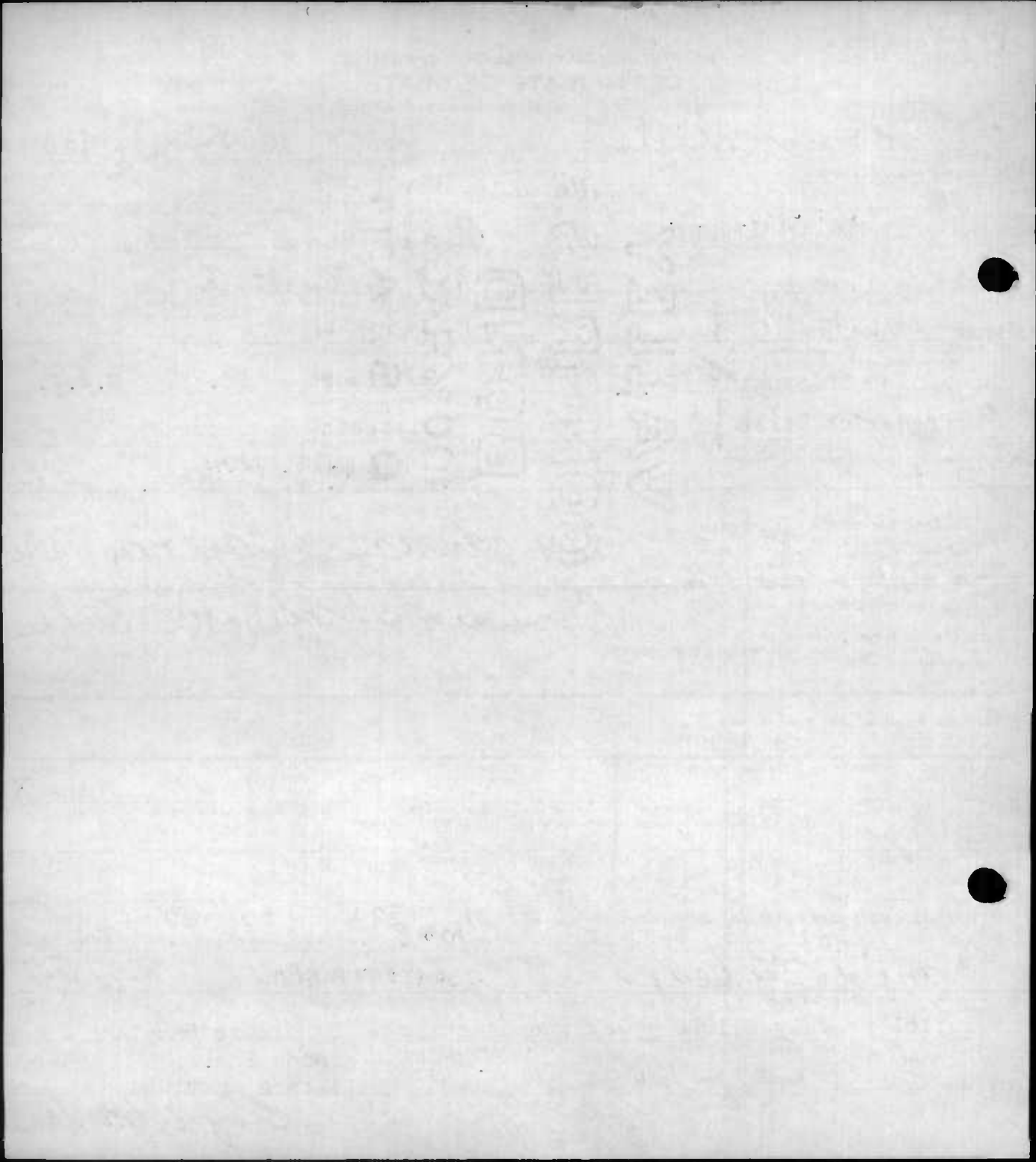
BIRTH NO.

|   |                                  |   |  |  |   |
|---|----------------------------------|---|--|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <u>Harry Wille</u>   |                                  |   | 2. DATE OF DEATH <u>July 1, 1950</u>   |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>md.</u> B. COUNTY |  |   |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><u>JOHNS HOPKINS HOSPITAL</u>  |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><u>Baltimore - 24 26-11</u>            |  |   |
| 6. Length of stay in Baltimore <u>Life</u>  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><u>919 S. East Ave.</u>   |  |   |
| 5. SEX<br><u>male</u>   | 6. COLOR OR RACE<br><u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><u>married</u>   | 8. DATE OF BIRTH<br><u>11-1-94</u>   | 9. AGE (in years last birthday)<br><u>55</u>                             | If Under 1 Year<br>Months: Days<br>If Under 24 Hours<br>Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Machinist instructor</u>  |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Naval Gun Factory D.C.</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Baltimore Md.</u>        |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |                                  |   | 13. FATHER'S NAME<br><u>Frederick Wille</u>  |  |   |
| 14. MOTHER'S MAIDEN NAME<br><u>Elizabeth Hildebrandt</u>  |                                  |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><u>NO</u>                       |  |   |
| 16. SOCIAL SECURITY NO.<br><u>NONE</u>  |                                  |   | 17. INFORMANT<br><u>JOHNS HOPKINS HOSPITAL</u><br><u>Mrs. Mary M. Wille 919 S. East Ave</u>                            |  |   |
| 18. <u>420.1</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><u>Myocardial Infarction</u><br>DUE TO<br><u>Coronary Thrombosis</u><br>DUE TO<br>DUE TO<br>INTERVAL BETWEEN ONSET AND DEATH |                                  |   |  |  |   |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                                  |   |  |  |   |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |  |  |   |
| 21A. DATE OF OPERATION <u>0</u>   |                                  | 21B. MAJOR FINDINGS OF OPERATION  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <u>5-31</u> , 19 <u>50</u> , to <u>7-1</u> , 19 <u>50</u> that I last saw the deceased alive on <u>7-1</u> , 19 <u>50</u> , and that death occurred at <u>10:10 P.M.</u> , from the causes and on the date stated above.   |                                  |   |  |  |   |
| 23A. SIGNATURE<br><u>David Suckers</u><br>M. D.   |                                  | 23B. ADDRESS<br><u>JOHNS HOPKINS HOSPITAL</u>   |  | 23C. DATE SIGNED<br><u>7-2-50</u>  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 24B. DATE<br><u>July 5, 1950</u>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Oaklawn cemetery</u>            |   |
| 24D. LOCATION (City, town, or county)<br><u>Baltimore Maryland</u>  |                                  | 24E. FUNERAL DIRECTOR<br><u>H. Sander &amp; Sons Inc.</u>   |  | 24F. ADDRESS<br><u>Baltimore Maryland</u>                                |   |
| DATE RECEIVED BY LOCAL REGISTRAR<br><u>JUL 3-1950</u>   |                                  | REGISTRAR'S SIGNATURE<br><u>Thurston Williams, M.D.</u>   |  | 5443D  |   |

VS 150

94a Scott F. Sander





F-636  
50 5835BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 5835

BIRTH NO.

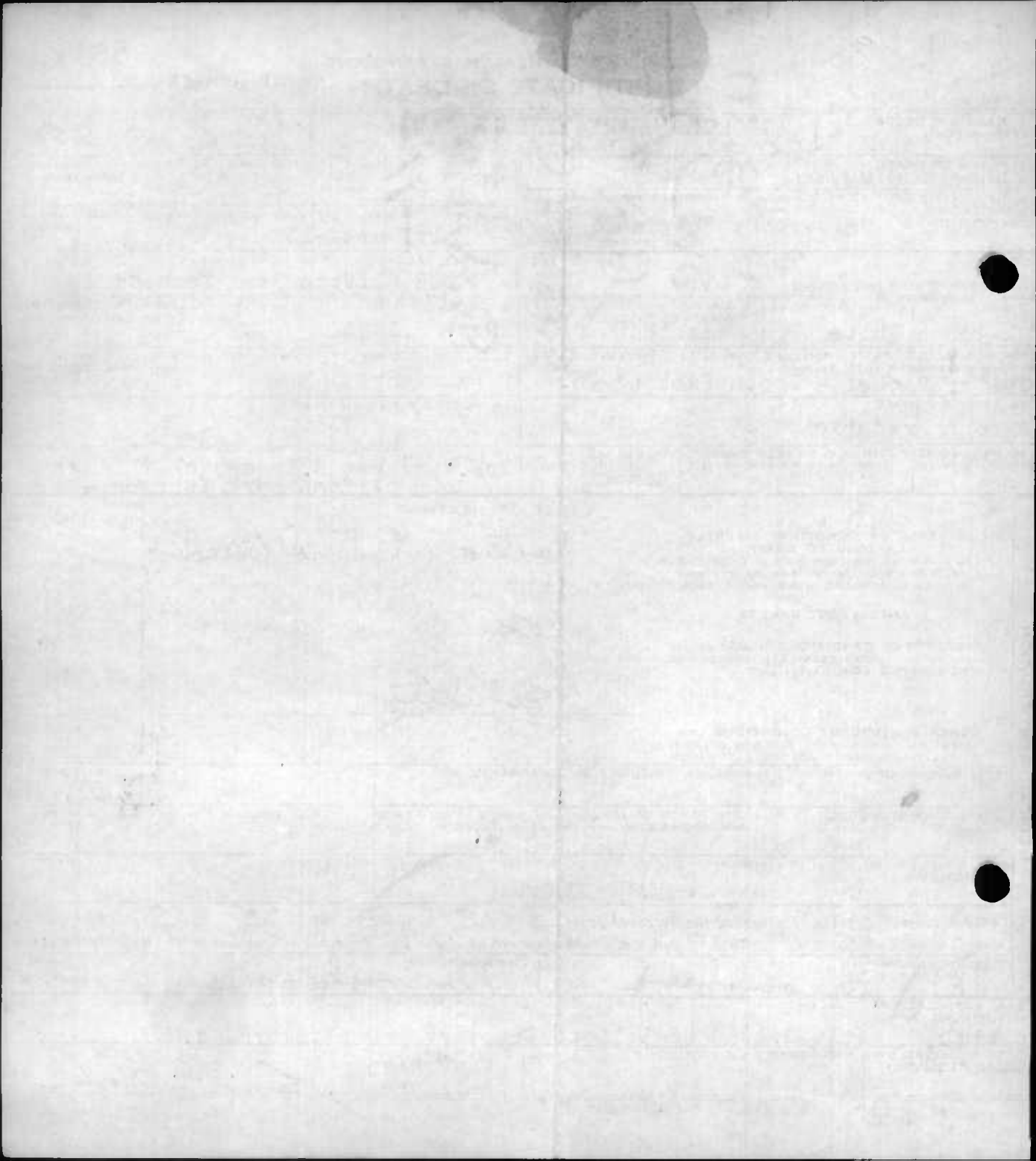
|   |                               |  |                                       |
|---|-------------------------------|--|---------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>George Henry Frederick</b>  |                               | 2. DATE OF DEATH <b>6-30-50</b>  |                                       |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                               | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |                                       |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital</b>  |                               | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore -13 8-01</b>                      |                                       |
| C. Length of stay in Baltimore <b>Life</b><br>Yrs. Mos. Days  |                               | D. STREET ADDRESS (If rural, give location)<br><b>3008 Clifton Park Terrace</b>  |                                       |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>   | 8. DATE OF BIRTH <b>Nov. 22, 1863</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Oyster Packer - Booth Packing Co.</b> |                               | 10B. KIND OF BUSINESS OR INDUSTRY  |                                       |
| 13. FATHER'S NAME <b>John Frederick</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>Mary ?</b>   |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>   |                               | 16. SOCIAL SECURITY NO. <b>none</b>  |                                       |
| 17. INFORMANT <b>Mrs. Margaret A. Frederick (Widow)</b>   |                               | ADDRESS <b>3008 Clifton Park Terrace -13</b>   |                                       |

|   |  |                                  |
|---|--|----------------------------------|
| 18. <b>578X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Antecedent Causes</b><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | CAUSE OF DEATH<br><b> gastro-intestinal bleeding</b><br>(A) DUE TO<br><b> Cause unknown</b><br>(B) DUE TO<br><b> Semblity</b><br>(C) | INTERVAL BETWEEN ONSET AND DEATH |
|---|--|----------------------------------|

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 19A. DATE OF OPERATION <b>✓</b>  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>5-18</b> , 19 <b>50</b> , to <b>6-30</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>6-30</b> , 19 <b>50</b> , and that death occurred at <b>12<sup>15</sup> Pm.</b> , from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE <b>E. J. Broadbent</b><br>M. D.   |  | 23B. ADDRESS <b>University Hospital</b>   |  | 23C. DATE SIGNED <b>6-30-50</b>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 24B. DATE <b>July 3, 1950</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>                        |  |
| 24D. LOCATION (City, town, or county) <b>Baltimore Md.</b>   |  | 24E. LOCATION (State)   |  | 25. FUNERAL DIRECTOR <b>HENRY SANDER &amp; SONS, INC.</b><br><b>Baltimore Md.</b>   |  |
| DATE RECEIVED BY LOCAL REGISTRAR   |  | REGISTRAR'S SIGNATURE <b>Washington Williams, M.D.</b>  |  | ADDRESS <b>Henry P. Sander</b>  |  |

JUL 30-1950

123



P-200  
50 5836

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5836

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARY ANN PAGE

2. DATE  
OF  
DEATH

7/1/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Balto

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

UNIVERSITY Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore, Maryland

C. Length of stay in Baltimore

46 YRS

D. STREET ADDRESS (If rural, give location)

5318 PENMORCA AVE 27-18

5. SEX

F

6. COLOR OR RACE

Negros

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

widow

8. DATE OF BIRTH

6-12-1887

9. AGE (In years last birthday)

63

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

Halifax, VA.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

BEN HOLLAWAY

14. MOTHER'S MAIDEN NAME

Emily Rodgers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

—

17. INFORMANT

ADDRESS

ERNEST PAGE-5318 PENMORCA

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Intaperitoneal & pleural hemorrhage

1 day

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Cir Colon

9 weeks

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Hypertensive Art-scler, Cardi-Vasc Disease

19A. DATE OF OPERATION

4/6/50

19B. MAJOR FINDINGS OF OPERATION

Cir Colon

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)

INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/24, 1950, to 7/1, 1950, that I last saw the deceased alive on 6/30, 1950, and that death occurred at 2:25 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Charles T. Henderson

M. D.

23B. ADDRESS

UNIV. Hospital

23C. DATE SIGNED

7/2/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

7/5/50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cem

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wm. Williams, M.D.

25. FUNERAL DIRECTOR

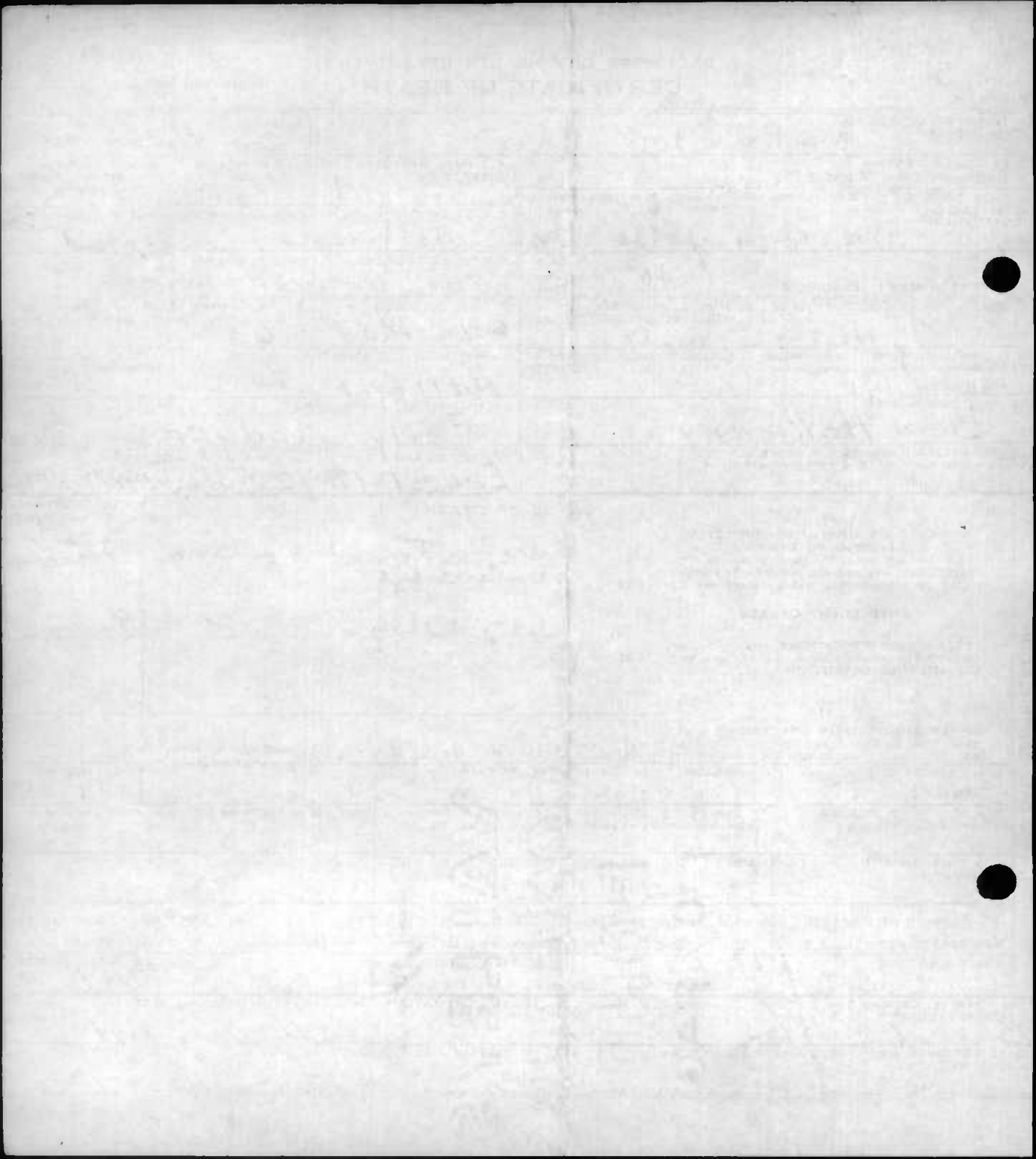
ADDRESS

Charles F. Law-802 Md. Ave.

JUL 3 - 1950

VS 150

46E



W-623

50 5837

50 5837

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

|  |                           |  |  |   |                              |
|--|---------------------------|--|--|---|------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <i>William J. Wright</i>  |                           |  | 2. DATE OF DEATH <i>7/1/50</i>   |   |                              |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>2318 Riggs Ave.</i>   |                           |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <i>MD</i> B. COUNTY <i>16-05</i> |   |                              |
| B. FULL NAME OF HOSPITAL OR INSTITUTION  |                           |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Balto Md.</i>                                   |   |                              |
| C. Length of stay in Baltimore <i>68</i> Yrs. Mos. Days  |                           |  | D. STREET ADDRESS (If rural, give location)<br><i>2318 Riggs Ave</i>   |   |                              |
| 5. SEX <i>m</i>  | 6. COLOR OR RACE <i>w</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i> | 8. DATE OF BIRTH <i>Sept 21-1890</i>   | 9. AGE (In years last birthday) <i>69</i> | 10. Under 1 Year Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Sexton of Holy Trinity Church, Chevy Chase</i> |                           |  | 11. BIRTHPLACE (State or foreign country) <i>Virginia</i>  |   |                              |
| 13. FATHER'S NAME <i>William T. Wright</i>   |                           |  | 14. MOTHER'S MAIDEN NAME <i>Virginia Hobitt</i>  |   |                              |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>  |                           |  | 16. SOCIAL SECURITY NO. <i>no</i>  |   |                              |
| 17. INFORMANT <i>Mrs Annie M. Wright</i>   |                           |  | ADDRESS  |   |                              |

|   |                                 |                                  |
|---|---------------------------------|----------------------------------|
| 18. <i>420.1</i>  | CAUSE OF DEATH                  | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) <i>Bronchial Pneumonia.</i> |                                  |
| ANTECEDENT CAUSES   | (B) <i>Coronary Occlusion.</i>  |                                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   | (C)                             |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                                 |                                  |

|  |   |  |
|--|---|--|
| 19A. DATE OF OPERATION <i>none</i>           | 19B. MAJOR FINDINGS OF OPERATION  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |

22. I hereby certify that I attended the deceased from *June 25*, 19*50* to *July 1*, 19*50*, that I last saw the deceased alive on *June 28*, 19*50*, and that death occurred at *m.*, from the causes and on the date stated above.

23A. SIGNATURE *George E. Shannon* M. D. 23B. ADDRESS *820 Medical Arts Bldg* 23C. DATE SIGNED *7/1/50*

|   |   |  |  |
|---|---|--|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 24B. DATE <i>7/4/50</i>                               | 24C. NAME OF CEMETERY OR CREMATORY <i>Louisa Park Ceme</i> | 24D. LOCATION (City, town, or county) (State) <i>Frederick Ave</i> |
| DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 3 1950</i>      | REGISTRAR'S SIGNATURE <i>William J. Shannon, M.D.</i> | 25. FUNERAL DIRECTOR <i>Charles P. Powell</i>              | ADDRESS <i>2427 Edmondson Ave.</i>                                 |





F-260

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5838

Registered No.

BIRTH NO. 50 5838

|  |                                  |   |   |  |  |
|--|----------------------------------|---|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Wm H. Fisher Sr</i>  |                                  |   | 2. DATE OF DEATH <i>July 1<sup>st</sup> 1950</i>  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>1220 N. Montford Ave</i>                                |                                  |   | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <i>Md.</i><br>B. COUNTY <i>8-04</i> |  |  |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION  |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Balto.</i>   |  |  |
| 6. Length of stay in Baltimore <i>Life</i>   |                                  |   | D. STREET ADDRESS (If rural, give location)<br><i>1220 N. Montford Ave</i>  |  |  |
| 7. SEX<br><i>Male</i>  | 8. COLOR OR RACE<br><i>White</i> | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Married</i> | 10. DATE OF BIRTH<br><i>April 7<sup>th</sup> 1890</i>   |  |  |
| 11. USUAL OCCUPATION (Give kind of work during most of working life, even if retired)<br><i>Lithographer</i> |                                  |   | 12. AGE (In years last birthday) <i>60</i>  |  |  |
| 13. FATHER'S NAME<br><i>Wm H. Fisher</i>   |                                  |   | 14. BIRTHPLACE (State or foreign country)<br><i>Md.</i>   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)                          |                                  |   | 16. CITIZEN OF WHAT COUNTRY?  |  |  |
| 17. SOCIAL SECURITY NO.  |                                  |   | 18. MOTHER'S MAIDEN NAME<br><i>Eliza Barrettson</i>   |  |  |
| 19. INFORMANT<br><i>Mrs Anna B Fisher</i>  |                                  |   | 20. ADDRESS<br><i>1220 N. Montford Ave</i>  |  |  |

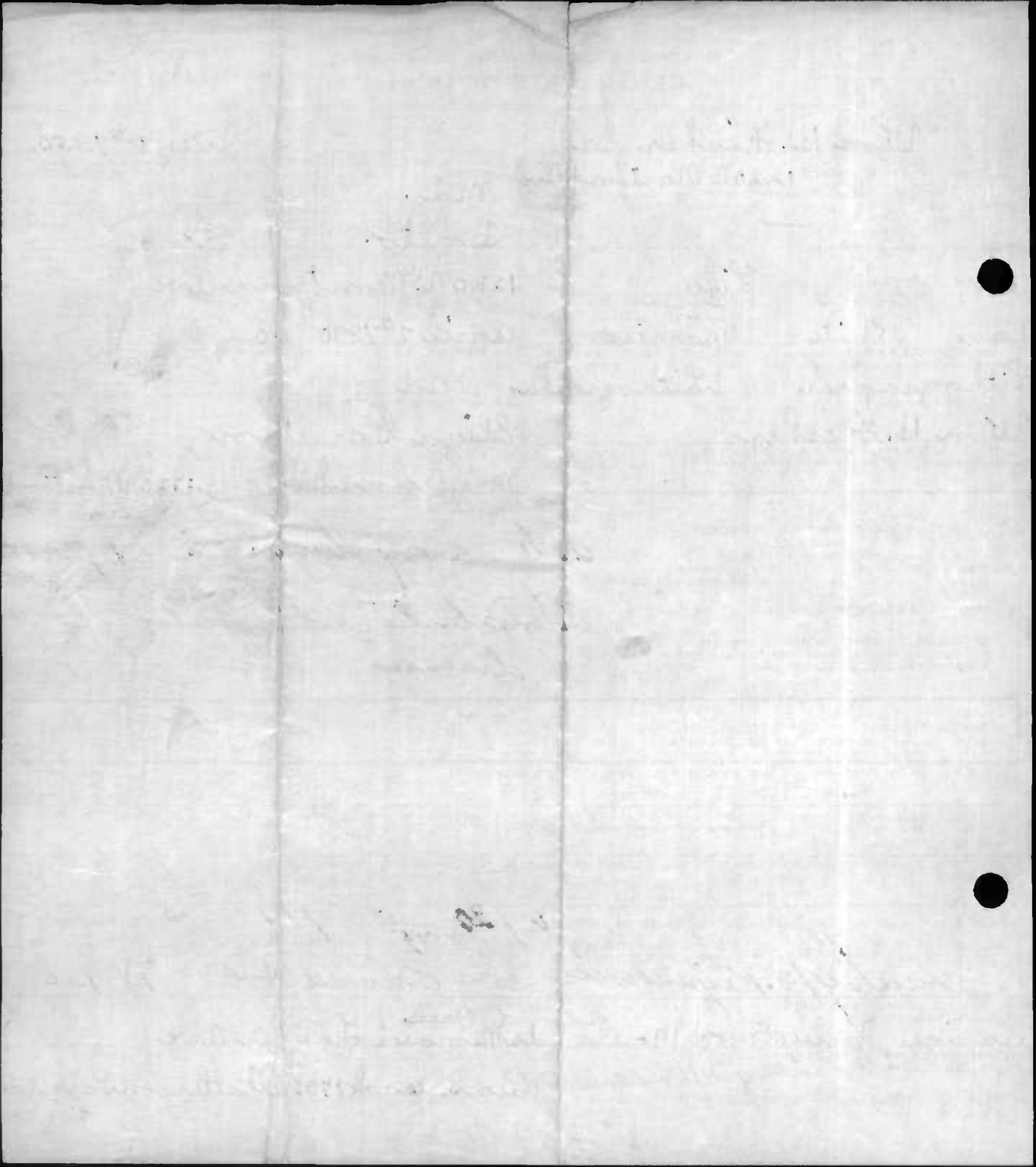
|   |  |                |  |                                  |  |
|---|--|----------------|--|----------------------------------|--|
| 18. <i>4/20/1</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) |  | CAUSE OF DEATH |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| (A) <i>acute coronary thrombosis</i>  |  | DUE TO         |  | <i>1 year</i>                    |  |
| (B) <i>atherosclerotic cardiovascular disease</i>   |  | DUE TO         |  |                                  |  |
| (C)   |  |                |  |                                  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |                |  |                                  |  |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 19A. DATE OF OPERATION <i>0</i>  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>    |  |
| 21A. ACCIDENT WAS UNDER-<br>LYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location) |  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>OF INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <i>6/30</i> , 1950, to <i>7/1</i> , 1950, that I last saw the deceased alive on <i>7/1</i> , 1950, and that death occurred at <i>8:45</i> m., from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE<br><i>Stanley B. Klyanowicz</i>   |  | 23B. ADDRESS<br><i>3500 Erdman Ave</i>  |  | 23C. DATE SIGNED<br><i>7/1/50</i>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  |  | 24B. DATE<br><i>July 5, 1950</i>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Morelands Memorial Park</i>        |  |
| 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore, Md.</i>   |  | 24E. NAME OF CEMETERY OR CREMATORY<br><i>Morelands Memorial Park</i>                                      |  | 24F. LOCATION (City, town, or county) (State)<br><i>Baltimore, Md.</i>      |  |
| 25. FUNERAL DIRECTOR<br><i>Leah S. Cook</i>  |  | 25. ADDRESS<br><i>1703 N. Patterson Park Ave</i>  |  | 25. ADDRESS<br><i>1703 N. Patterson Park Ave</i>                            |  |

JUL 3 - 1950

5714M

93D



K-620

50 5839

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5839  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARY Elizabeth KRAUSE

2. DATE  
OF  
DEATH

7-2-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR

INSTITUTION

Union Memorial Hospital

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR  
INDUSTRY

13. FATHER'S NAME

Richard Krause

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or none known) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

8. DATE OF BIRTH

May 1, 1927

9. AGE (In years  
last birthday)

23

11 Under 1 Year

Months: Days

18 Under 24 Hours

Hours: Min.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

Elizabeth Brown

17. INFORMANT

ADDRESS

H. M. J. Stiegel

6202 York Rd

18. 401.3 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

CEREBRAL EMBOLISM

DUE TO

ANTECEDENT CAUSES

(B)

RHEUMATIC HEART DISEASE

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

RHEUMATIC FEVER

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

PULMONARY EMBOLISM

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from MAY 1, 1950, to JULY 2, 1950, that I last saw the  
deceased alive on JULY 2, 1950, and that death occurred at 8:25 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Richard Beach

M. D.

23B. ADDRESS

Union Memorial Hospital

23C. DATE SIGNED

7-2-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

July 5, 1950

Moreland Memorial

Balto. Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 3 - 1950

Huntington Williams, M.D.

Henry H. Jenkins &amp; Sons

4905 York Rd



W-656

50 5840

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5840  
Registered No.

|  |                                  |  |   |   |  |
|--|----------------------------------|--|---|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>FLORA MELVIN WARNER</b>  |                                  |  | 2. DATE OF DEATH <b>7/1/50</b>  |   |  |
| 3. PLACE OF DEATH:<br>a. Baltimore City, Maryland <b>207 HAWTHORNE RD</b>  |                                  |  | 4. USUAL RESIDENCE (Where deceased lived before admission)<br>a. STATE <b>MD</b><br>b. COUNTY <b>BALTIMORE MD</b> |   |  |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>ADAPT</b>  |                                  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTIMORE MD</b>               |   |  |
| c. Length of stay in Baltimore <b>APPROX. 80</b> Yrs. Mos. Days  |                                  |  | d. STREET ADDRESS (If rural, give location)<br><b>27-14</b>   |   |  |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>WIDOW</b>  | 8. DATE OF BIRTH<br><b>MAY 14, 1857</b>   |   | 9. AGE (In years last birthday)<br><b>93</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>NONE</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>NONE</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>HAMPSTEAD, MD</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b> |
| 13. FATHER'S NAME<br><b>ALEXANDER MYERS</b>  |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>MARTHA A. ALGUIPE</b>  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>NO</b>   |                                  | 16. SOCIAL SECURITY NO.  | 17. INFORMANT ADDRESS<br><b>DOUGLAS WARNER BALTO. MD</b>  |   |  |
| 18. <b>422.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br>(A) <b>Congestive Heart Failure</b><br>DUE TO<br>(B) <b>Arterio-sclerotic Myocarditis</b><br>DUE TO<br>(C) <b>Gradual</b> |                                  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b>   |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                                  |  |   |   |  |
| 19a. DATE OF OPERATION <b>0</b>  |                                  | 19b. MAJOR FINDINGS OF OPERATION   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                                  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |   | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |   | 21f. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>July 1, 1950</b> to <b>July 1, 1950</b> that I last saw the deceased alive on <b>July 1, 1950</b> and that death occurred at <b>11:50 AM</b> from the causes and on the date stated above.   |                                  |  |   |   |  |
| 23a. SIGNATURE<br><b>W. H. Maady</b>   |                                  | 23b. ADDRESS<br>M. D. <b>1403 Park Ave</b>   |   | 23c. DATE SIGNED<br><b>7-3-50</b>   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 24b. DATE<br><b>July 3, 1950</b>   |   | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Landon Park Cem.</b>                       |  |
| 24d. LOCATION (City, town, or county) (State)<br><b>Baltimore Md</b>   |                                  | 25. FUNERAL DIRECTOR<br><b>Henry W. Jenkins &amp; Sons Co.</b>   |   | ADDRESS<br><b>14965 York Rd 93D</b>   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>Thurston Williams</b>   |                                  | REGISTRAR'S SIGNATURE  |   |   |  |

JUL 3 1950



Mr. Moody  
1402 Jackson

W-430  
50 5841BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 584P

BIRTH NO.

|  |                              |   |   |   |                                  |
|--|------------------------------|---|---|---|----------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>ELISE S.M. Wild</b>  |                              |   | 2. DATE OF DEATH<br><b>7-3-50</b>   |   |                                  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                              |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY |   |                                  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>Union Memorial Hospital</b> |                              |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 11-02</b>                      |   |                                  |
| C. Length of stay in Baltimore <b>81</b> Yrs. <b>81</b> Mos. <b>81</b> Days  |                              |   | D. STREET ADDRESS (If rural, give location)<br><b>928 Cathedral St.</b>   |   |                                  |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b> | 8. DATE OF BIRTH<br><b>unknown</b>  | 9. AGE (In years, last birthday)<br><b>81</b> | 10. Under 1 Year<br>Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>none</b>             |                              |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>   |   |                                  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                              |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |                                  |
| 13. FATHER'S NAME<br><b>J. Dietrich Moritz</b>   |                              |   | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Stewart</b>  |   |                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)<br><b>Unknown</b>                   |                              |   | 16. SOCIAL SECURITY NO.   |   |                                  |
| 17. INFORMANT<br><b>HOSP. REC.</b>   |                              |   | ADDRESS   |   |                                  |

|  |   |  |
|--|---|--|
| 18. <b>420.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Coronary Thrombosis</b><br>DUE TO<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Arteriosclerotic Hypertensive Cardiac Vascular Disease</b><br>DUE TO<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | CAUSE OF DEATH<br><b>Coronary Thrombosis</b><br><b>Arteriosclerotic Hypertensive Cardiac Vascular Disease</b> | INTERVAL BETWEEN ONSET AND DEATH<br><b>1/2 hour</b><br><b>many years</b> |
|--|---|--|

|   |   |  |   |   |  |
|---|---|--|---|---|--|
| 19A. DATE OF OPERATION <b>0</b>   |   | 19B. MAJOR FINDINGS OF OPERATION   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br><b>INJURY</b>  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |   |  |
| 22. I hereby certify that I attended the deceased from <b>7-2</b> , 19 <b>50</b> , to <b>7-3</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>7-3</b> , 19 <b>50</b> , and that death occurred at <b>4:10 P.m.</b> , from the causes and on the date stated above. |   |  |   |   |  |
| 23A. SIGNATURE<br><b>Alfred S. Nelson</b>   |   | 23B. ADDRESS<br><b>Baltimore 18 Maryland</b>                             |   | 23C. DATE SIGNED<br><b>July 3, 1950</b>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 24B. DATE<br><b>July 5 1950</b>   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b>                 | 24D. LOCATION (City, town, or county) (State)<br><b>Balds. Md</b> |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 3 - 1950</b>   |   | REGISTRAR'S SIGNATURE<br><b>Wilmington Williams, M.D.</b>                |   | 25. FUNERAL DIRECTOR<br><b>Henry H. Jenkins r/Amco 4905 York Rd</b>                 |  |

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

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BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

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WASHINGTON, D. C.

M-5036842

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5842  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

PACA MOORES MAYNADIER

2. DATE

OF DEATH JULY 1, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 804 EVESHAM AVE

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

804 EVESHAM AVE

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE 12 MD.

D. STREET ADDRESS (If rural, give location)

JAN.

27-48

E. Length of stay in Baltimore

9 YRS.

Yrs.  
Mos.  
Days

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

SINGLE

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

BANKING

13. FATHER'S NAME

GEORGE YELLOTT MAYNADIER

8. DATE OF BIRTH 1873

JAN 26 1873

9. AGE (In years last birthday)

77

11 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

11. BIRTHPLACE (State or foreign country)

BEL AIR MD

12. CITIZEN OF WHAT COUNTRY?

USA

14. MOTHER'S MAIDEN NAME

LAURA PACA MOORES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

212-10-7904A

17. INFORMANT

ADDRESS

COLIN F. MACKENZIE 522 ORKNEY RD.

18. 420.1 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Coronary Occlusion

1 week

ANTECEDENT CAUSES

(B) DUE TO

Arteriosclerosis

7 yrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) DUE TO

Senility

7 yrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

None

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from June 24, 1950, to July 12, 1950, that I last saw the deceased alive on June 27, 1950, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

A.S. Channing

6210 York Rd

July 3, 50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

L 5-1950

Rock Spring Forrest Hill Md.

Henry W. Jenkins &amp; Sons Co.

4905 York Rd. 94a

H. Chalfant  
6210 York Rd.  
8:30 a.m.

L-163

50 5843

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 50-08007

1. NAME OF DECEASED  
(Type or Print)

FRANCIS JOSEPH LIBERTO

2. DATE  
OF  
DEATH

7-1-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION

University Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

4-02

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

606 W. Lexington St

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Infant

8. DATE OF BIRTH

April 14-1950

9. AGE (In years last birthday)

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

August Liberto

14. MOTHER'S MAIDEN NAME

Rosemarie Tumminello

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Rosemarie Liberto 606 W. Lexington

18. 274X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Adrenal-Cortical Insufficiency

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Meningitis - Septicemia  
Aidrosis

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

INJURY

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 6:30, 1950, to 7:1, 1950, that I last saw the deceased alive on 7/1, 1950, and that death occurred at 11 P. m., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

UL 3-1950

VS 150

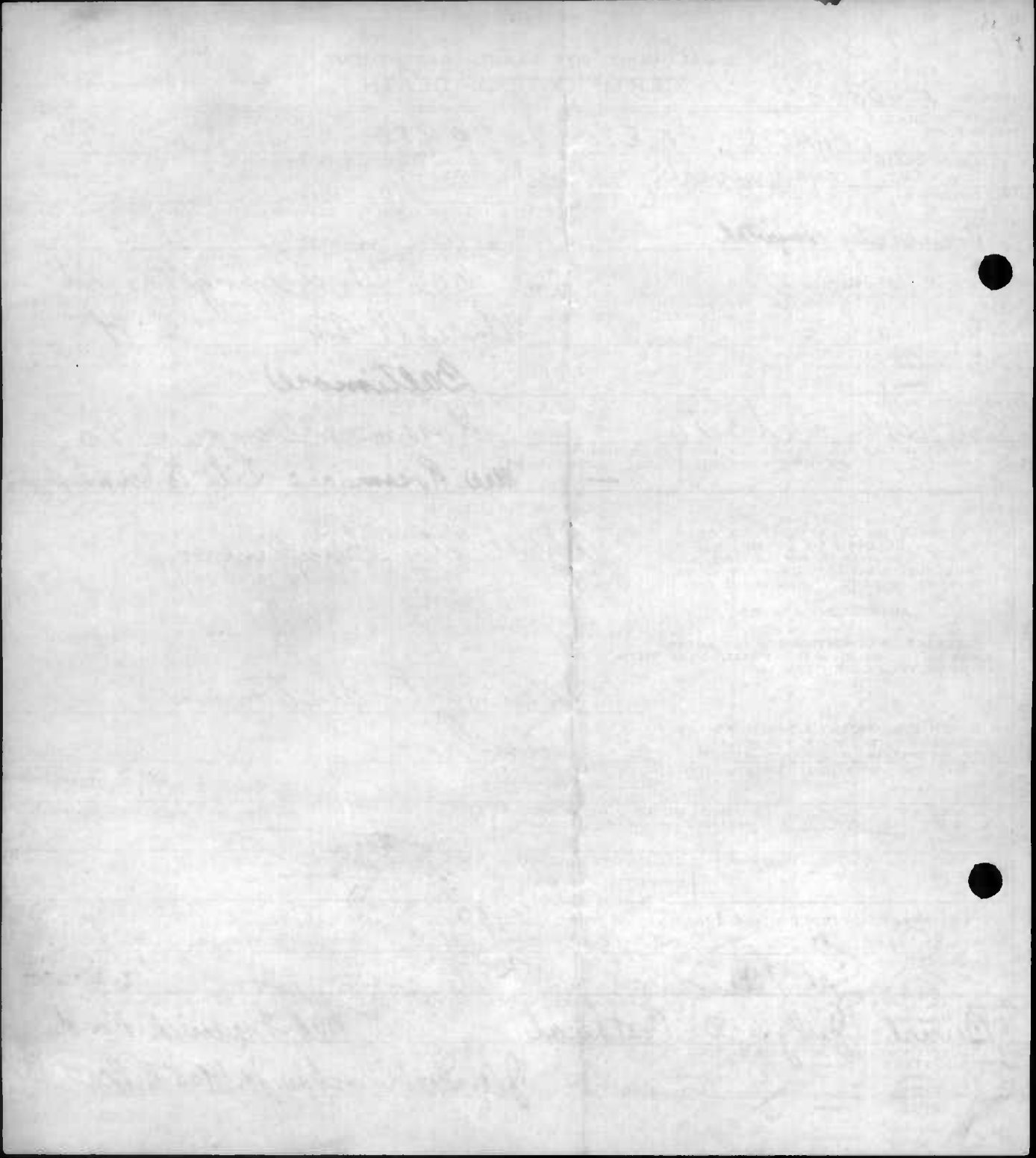
Baltimore William, M.D.

J. A. Treblanck, Jr. 1905 E. Pratt St.

65B

MEDICAL CERTIFICATION





B-536 5844

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5844  
Registered No.

BIRTH NO. 550

1. NAME OF DECEASED (Type or Print) **WILLIAM Charles (BYNUMM) Bracy Bynder** 2. DATE OF DEATH **June 29, 1950**

3. PLACE OF DEATH: A. Baltimore City, Maryland 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE **Maryland** B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location) **Franklin Square Hospital** C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore** 25-06

D. STREET ADDRESS (If rural, give location) **1502 Brady Street**

Length of stay in Baltimore ? Yrs. Mos. Days

5. SEX **Male** 6. COLOR OR RACE **Colored** 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **S** 8. DATE OF BIRTH **1923** 9. AGE (In years last birthday) **27** If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Laborer** 10B. KIND OF BUSINESS OR INDUSTRY **Unknown** 11. BIRTHPLACE (State or foreign country) **Whiteville, N. C.** 12. CITIZEN OF WHAT COUNTRY? **U. S. A.**

13. FATHER'S NAME **Burney Bracy** 14. MOTHER'S MAIDEN NAME **?**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) **yes** (If yes, give war or dates of service) **W. W. #2** 16. SOCIAL SECURITY NO. **214-20-9678** 17. INFORMANT **John W. Shaw & Son** ADDRESS **Whiteville, N. C.**

18. **E981X** CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) **Bullet wounds of chest and back with perforation of abdominal viscera** DUE TO

ANTECEDENT CAUSES (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) **A home** 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) **17 N. Norris Street**

21D. TIME (Month) (Day) (Year) (Hour) **June 29, 1950 7:20 P. m.** 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 21F. HOW DID INJURY OCCUR? **Firearms**

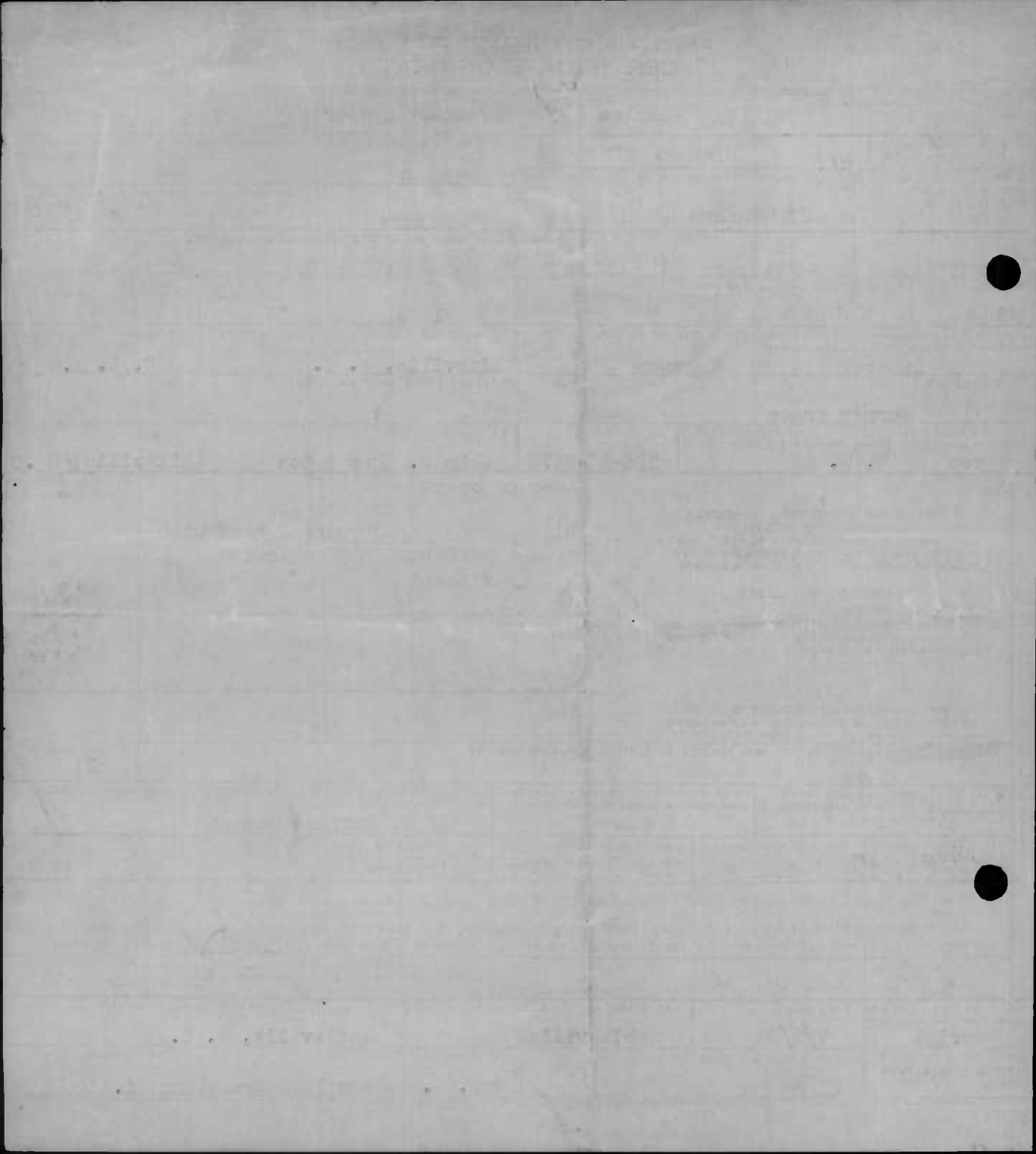
I certify that I took charge of the remains described above, held an **Autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.

23A. SIGNATURE **Stanley K. Ducloux M.D.** 23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☒ 23C. DATE SIGNED **6-30-50**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **7/5/50** 24C. NAME OF CEMETERY OR CREMATORY **Whiteville** 24D. LOCATION (City, town, or county) (State) **Whiteville, N. C.**

DATE RECEIVED BY LOCAL HEALTH DEPARTMENT **UL 3-1950** REGISTRAR'S SIGNATURE **Wilmington Williams, Jr.** 25. FUNERAL DIRECTOR **Geo. G. Kelson 1303 Presstman St.** ADDRESS

VS 151 **N-8694** **98899** **166** ✓



F-450  
50 5845  
JL-139318BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5845

BIRTH NO.

|   |                                  |   |   |  |   |
|---|----------------------------------|---|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Joseph Fullum</b>   |                                  |   | 2. DATE OF DEATH<br><b>6-30-50</b>  |  |   |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>  |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Ma.</b><br>B. COUNTY |  |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>Baltimore City Hospitals</b><br><b>4940 Eastern Ave.</b> |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>1-02</b>              |  |   |
| C. Length of stay in Baltimore <b>Life</b>  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>14 S. Robinson St.</b>  |  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b> | 8. DATE OF BIRTH<br><b>May 24, 1873</b>   | 9. AGE (in years last birthday)<br><b>77</b> | If Under 1 Year<br>Months: Days<br>If Under 24 Hours<br>Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Printer</b>                               |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Newspapers</b>            | 11. BIRTHPLACE (State or foreign country)<br><b>Ma.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?  |
| 13. FATHER'S NAME<br><b>James Fullum</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Tulford</b>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>Unknown</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>none</b>                            | 17. INFORMANT ADDRESS<br><b>B. C. H. Records, 4940 Eastern Ave.</b>   |  |   |

|  |                                  |
|--|----------------------------------|
| 18. <b>331X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cerebral Vascular Hemorrhage</b><br>DUE TO<br><b>General Arteriosclerosis</b><br>DUE TO<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | INTERVAL BETWEEN ONSET AND DEATH |
|--|----------------------------------|

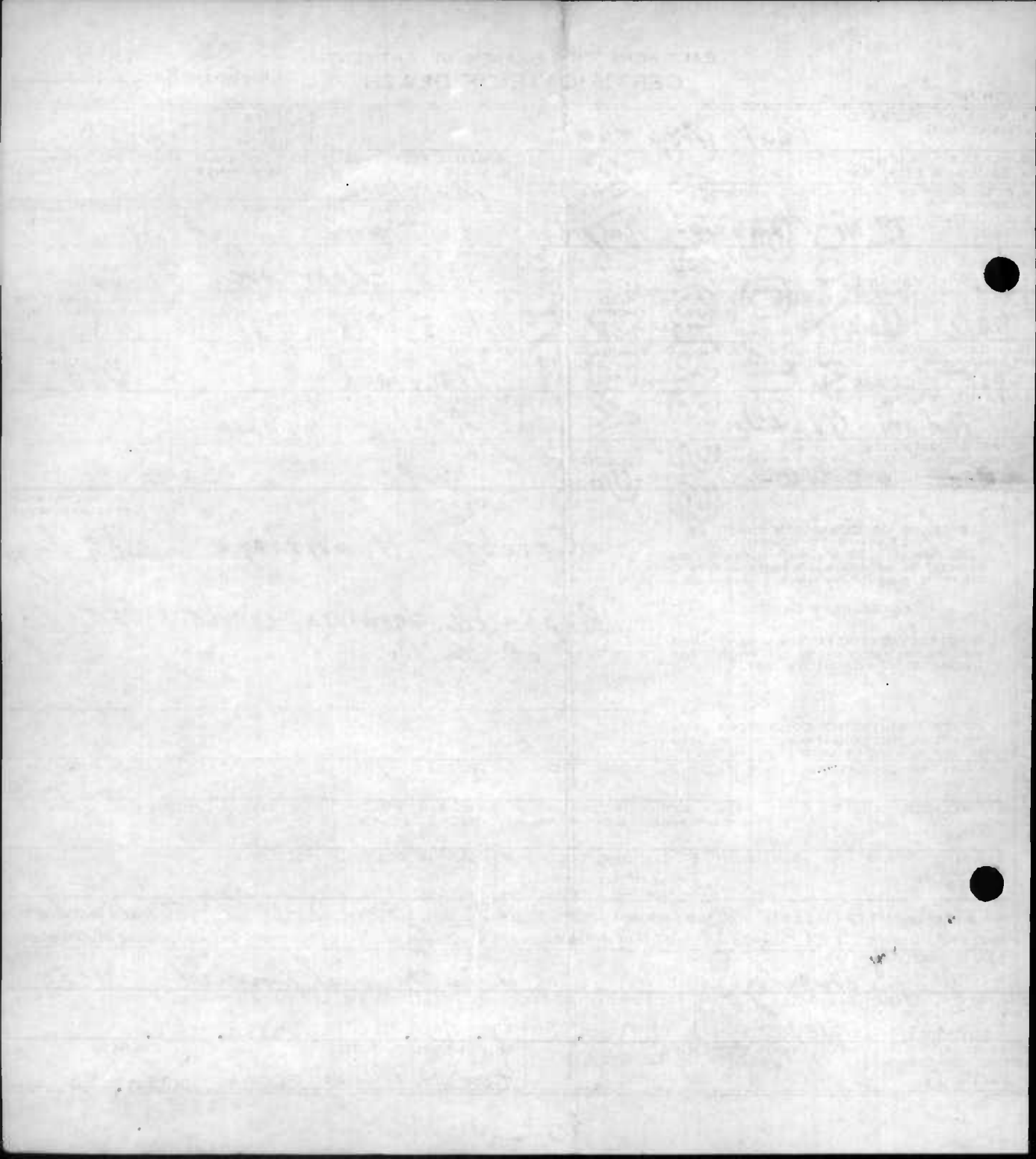
|  |   |  |  |   |  |
|--|---|--|--|---|--|
| 19A. DATE OF OPERATION <b>7</b>  |   | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDER- LYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED<br>WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK | 21F. HOW DID INJURY OCCUR?   |  |   |  |
| 22. I hereby certify that I attended the deceased from <b>6-29-</b> <b>1950</b> , to <b>6-30-</b> <b>1950</b> , that I last saw the deceased alive on <b>6-30-</b> <b>1950</b> , and that death occurred at <b>5 PM.</b> , from the causes and on the date stated above. |   |  |  |   |  |
| 23A. SIGNATURE<br><b>W. J. J. J.</b>   |   | 23B. ADDRESS<br><b>4940 Eastern Avenue</b>                               |  | 23C. DATE SIGNED<br><b>7-1-50</b>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 24B. DATE<br><b>7/4/50</b>  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Cem.</b>               | 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b> |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR   | REGISTRAR'S SIGNATURE<br><b>Thurston Williams, M.D.</b>   | 25. FUNERAL DIRECTOR<br><b>John A. Moran</b>                             |  | ADDRESS<br><b>3000 E. Balto. St.</b>  |  |



50 5846  
N-250BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5846  
Registered No.

|  |                                  |  |   |   |   |
|--|----------------------------------|--|---|---|---|
| BIRTH NO.  |                                  | 1. NAME OF DECEASED<br>(Type or Print) <i>Paul Newkum</i>  |   | 2. DATE OF DEATH<br><i>2-1-50</i>   |   |
| 3. PLACE OF DEATH:<br>a. Baltimore City, Maryland  |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <i>Maryland</i><br>b. COUNTY <i>9-01</i> |   |   |   |
| b. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>Union Memorial Hospital</i>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore</i>   |   |   |   |
| c. Length of stay in Baltimore<br><i>Life</i>  |                                  | d. STREET ADDRESS (If rural, give location)<br><i>3913 Ednor Ave., Balto</i>   |   |   |   |
| 5. SEX<br><i>Male</i>  | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Married</i>  | 8. DATE OF BIRTH<br><i>July 5, 1918</i> | 9. AGE (In years last birthday)<br><i>31</i>  | 10. Under 1 Year<br>Months: Days: Hours: Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Cost Accountant</i>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Printing</i>   |   | 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>                        |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |                                  | 13. FATHER'S NAME<br><i>Adam Newkum</i>  |   | 14. MOTHER'S MAIDEN NAME<br><i>Amelia Hynson</i>                                    |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><i>Yes</i>  |                                  | 16. SOCIAL SECURITY NO.<br><i>WW12-1943-46 216-07-8169</i>   |   | 17. INFORMANT<br><i>Wife</i>  |   |
| 18. <i>452 X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Cerebral Hemorrhage</i><br>DUE TO<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><i>Ruptured aneurysm, circle of Willis</i><br>DUE TO<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                                  | CAUSE OF DEATH<br><i>Cerebral Hemorrhage</i><br><i>Ruptured aneurysm, circle of Willis</i>   |   | INTERVAL BETWEEN ONSET AND DEATH<br><i>3 1/2 days</i><br><i>3 1/2 days</i>          |   |
| 19a. DATE OF OPERATION<br><i>0</i>   |                                  | 19b. MAJOR FINDINGS OF OPERATION   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |                                  | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |   |
| 21d. TIME (Month) (Day) (Year) (Hour)<br><i>0</i>  |                                  | 21e. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                  |   | 21f. HOW DID INJURY OCCUR?  |   |
| 22. I hereby certify that I attended the deceased from <i>6-27</i> , 19 <i>50</i> , to <i>7-1</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>7-1</i> , 19 <i>50</i> , and that death occurred at <i>7:15</i> m., from the causes and on the date stated above.  |                                  |  |   |   |   |
| 23a. SIGNATURE<br><i>Ray D. Beverly Jr.</i>  |                                  | 23b. ADDRESS<br><i>Union Memorial Hospital</i>   |   | 23c. DATE SIGNED<br><i>7-1-50</i>   |   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                                  | 24b. DATE<br><i>7/5/50</i>   |   | 24c. NAME OF CEMETERY OR CREMATORY<br><i>Balto. Nat'l. Cem.</i>                     |   |
| 24d. LOCATION (City, town, or county) (State)<br><i>Balto. Md.</i>   |                                  | 24e. DATE RECEIVED BY LOCAL REGISTRAR<br><i>3-1950</i>   |   | 24f. REGISTRAR'S SIGNATURE<br><i>John A. Moran</i>                                  |   |
| 24g. FUNERAL DIRECTOR<br><i>John A. Moran</i>  |                                  | 24h. ADDRESS<br><i>3000 E Balto. St</i>  |   | 24i. 162  |   |





B-650  
50 5847BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5847

Registered No.

BIRTH NO.

|   |                                  |  |   |  |   |
|---|----------------------------------|--|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>ALEXANDER A. BARRON</b>   |                                  |  | 2. DATE OF DEATH <b>7-2-50</b>  |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Ind</b> B. COUNTY <b>6</b> |  |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION<br><b>Mersey Hospital</b> |                                  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>5-6-09</b>                  |  |   |
| C. Length of stay in Baltimore  |                                  |  | D. STREET ADDRESS (If rural, give location)<br><b>3700 Fair Ave. Zone 5-24</b>  |  |   |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, <u>MARRIED</u><br>WIDOWED, DIVORCED (Specify)   | 8. DATE OF BIRTH<br><b>12-2-94</b>  | 9. AGE (In years last birthday)<br><b>55</b>                 | 10. Under 1 Year<br>Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>UNEMPLOYED</b>                          |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>METAL POLISHER</b> |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b> |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                  |  | 13. FATHER'S NAME<br><b>George Barron</b>   |  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Agnes Levant</b>   |                                  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(If yes, give war or dates of service)<br><b>unk.</b>                           |  |   |
| 16. SOCIAL SECURITY NO.   |                                  |  | 17. INFORMANT<br><b>ANNA BARRON 3700 FAIR AVE.</b>  |  |   |

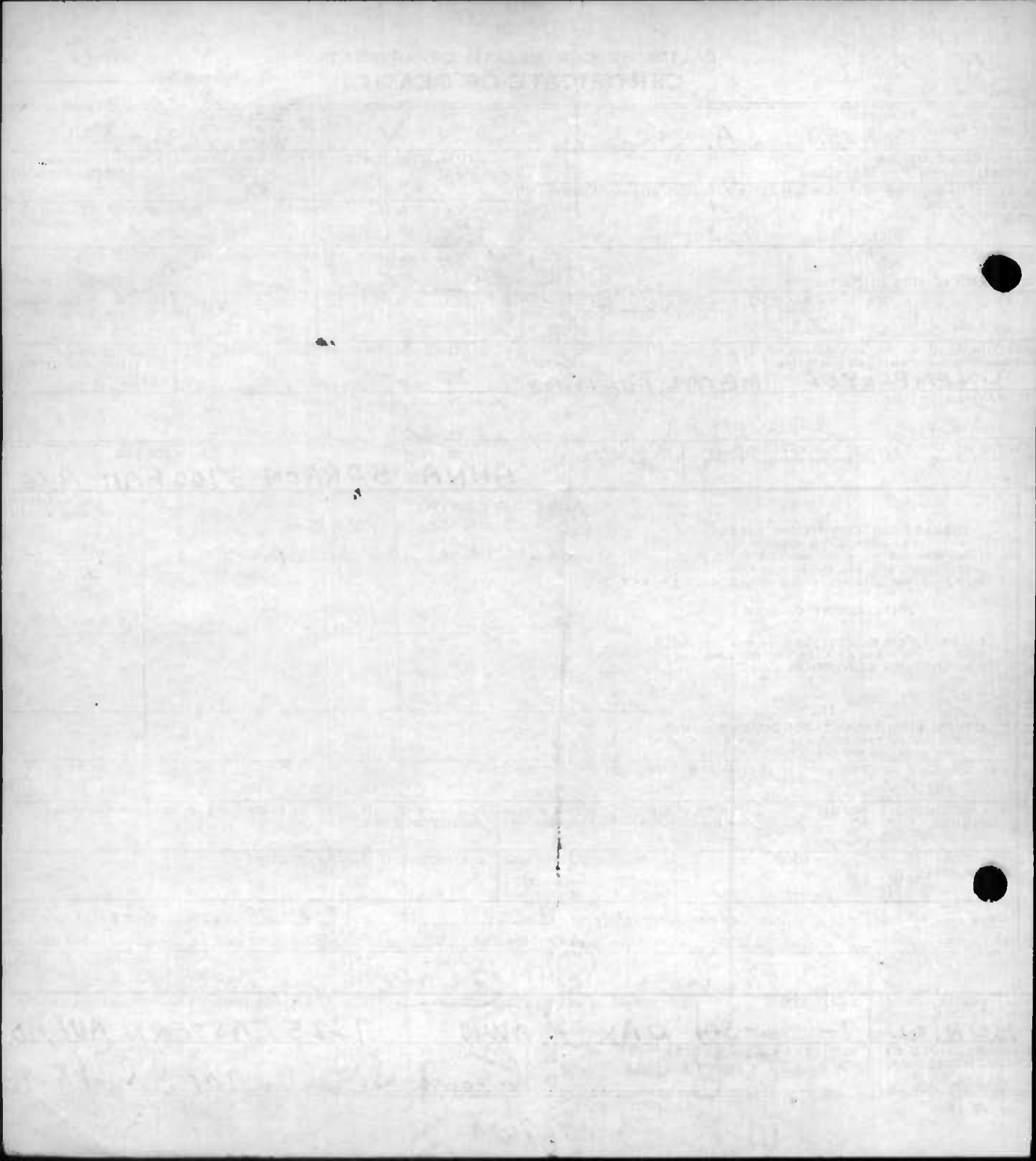
|  |  |
|--|--|
| 18. <b>156.1 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br>(A) <b>Bronchopneumonia</b><br><b>Acute renal insufficiency</b><br>DUE TO<br>(B) <b>Carcinoma of liver</b><br>DUE TO<br>(C) _____<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>6 weeks</b> |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |

|   |   |  |
|---|---|--|
| 19A. DATE OF OPERATION<br><b>none</b>                             | 19B. MAJOR FINDINGS OF OPERATION  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)<br><b>none</b>         | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>ON INJURY<br><b>none</b> | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |

22. I hereby certify that I attended the deceased from **7-1-50**, 19\_\_, to **7-2-50**, 19\_\_, that I last saw the deceased alive on **7-2-50**, 19\_\_, and that death occurred at **11:45 a.m.**, from the causes and on the date stated above.

|  |  |                                   |
|--|--|-----------------------------------|
| 23A. SIGNATURE<br><b>Fowler J. White</b> | 23B. ADDRESS<br>M. D. <b>5077 Orville Ave Zone 5</b> | 23C. DATE SIGNED<br><b>7-2-50</b> |
|--|--|-----------------------------------|

|  |   |  |   |
|--|---|--|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b> | 24B. DATE<br><b>7-5-50</b>                                | 24C. NAME OF CEMETERY OR CREMATORY<br><b>OAK LAWN</b>                | 24D. LOCATION (City, town, or county) (State)<br><b>7225 EASTERN AVE, MD.</b> |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>3-1950</b>          | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b> | 25. FUNERAL DIRECTOR<br><b>Charles S. Zeiler 901 S. Conkling St.</b> | ADDRESS   |



G-316  
50 5848

50 5848

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

FRANK J. GUTBERLET

2. DATE  
OF  
DEATH

July 1-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

5007 Eugene Ave.

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

5. SEX

MALE

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Engineer Stationery

10B. KIND OF BUSINESS OR  
INDUSTRY

Lock Ins. Co.

13. FATHER'S NAME

Charles GUTBERLET

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

213-05-8988

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

27-01

D. STREET ADDRESS (If rural, give location)

5007 Eugene Ave.

8. DATE OF BIRTH

June 18-1880

9. AGE (in years  
last birthday)

70

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Margaret Walch

17. INFORMANT

ADDRESS

Mrs. AUGUSTA GUTBERLET-5007 Eugene

18. 4201

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Coronary  
Arteriosclerotic Disease 2.4 hrs

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Generalized Arteriosclerosis ?

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Acute Nephritis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 27, 1950 to July 1, 1950, that I last saw the  
deceased alive on July 1, 1950, and that death occurred at 1:25 p. m., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial  
DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

3-1950

Leonard J. Ruck 5305 Hartford Rd

Dr. Sevik  
3601 H. 15th Ave.

50 5849

50 5849

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Vernon L. Wood

2. DATE  
OR  
DEATH

July 1, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

1011 Hanover St

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Md

B. COUNTY

C. CITY OR TOWNSHIP (If outside corporate limits, write RURAL and give township)

Balt

23-01

C. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

April 30, 1923

9. AGE (In years  
last birthday)

27

If Under 1 Year  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of  
orl. done during most of working life, even if retired)

Blue

10B. KIND OF BUSINESS OR  
INDUSTRY

Armo Druggist

11. BIRTHPLACE (State or foreign country)

Balt

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Harry W. Wood

14. MOTHER'S MAIDEN NAME

Anna S. Gray

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
Yes, no or unknown

No

16. SOCIAL  
SECURITY NO.

215-12-7442

17. INFORMANT

Harry W. Wood 1011 Hanover St

ADDRESS

18. 260X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Cerebral hemorrhage

3 days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B)

Cerebroarterio sclerosis

9½ mos.

DUE TO

(C)

Diabetes Mellitus

?

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/13/49, 19, to 7/1/50, 19, that I last saw the  
deceased alive on 7/1/50, 19, and that death occurred at 9:50P m., from the causes and on the date stated above.

23A. SIGNATURE

Harry Deibel

M. D.

23B. ADDRESS

1226 Hanover Street,

23C. DATE SIGNED

7/3/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

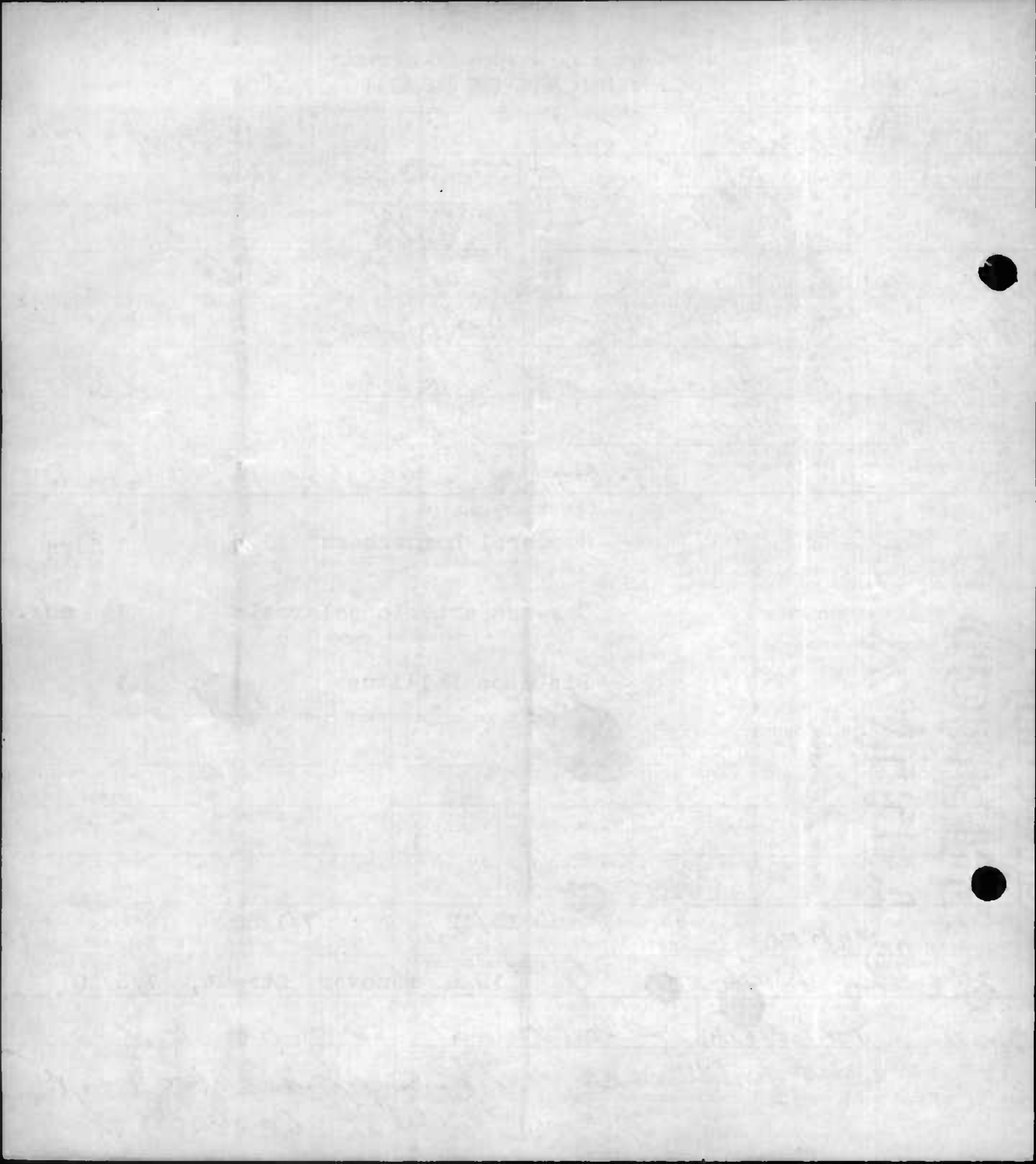
JL 3-1950

Huntington Williams, M.D.

P. Howard Evans 1400 S. 61

39024 Charles St. Balto. 39, Md





H-630

50 5850

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 5850

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mildred Hurt.

2. DATE  
OF  
DEATH

6-30-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

930 Durham St.

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE Maryland

B. COUNTY Baltimore city

C. CITY OR TOWN. (If outside corporate limits, write RURAL and give township)

Baltimore City

D. STREET ADDRESS (If rural, give location)

930 Durham.

7-04

C. Length of stay in Baltimore

life

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

widow

8. DATE OF BIRTH

1/3/1895

9. AGE (In years; last birthday)

55

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Robt. H. Elliott 1129 Caroline

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma left breast

4 years.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 6/30, 1950, to 6/30, 1950, that I last saw the deceased alive on 6/30, 1950, and that death occurred at 3:50 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

John M. Burnett

M. D.

Johns Hopkins Hospital

7/1/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

July 3/50

Mt Calvary Cem. &amp; Co County Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

3-1950

Mrs Robert A. Elliott &amp; Son

12-25-20

Wilmington, Delaware  
Fuller House  
300 West 1st St.

12-25-20

Wilmington, Delaware  
Fuller House  
300 West 1st St.  
Wilmington, Delaware

Wilmington, Delaware  
Fuller House  
300 West 1st St.

X

Wilmington, Delaware  
Fuller House  
300 West 1st St.  
Wilmington, Delaware  
Fuller House  
300 West 1st St.  
Wilmington, Delaware  
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300 West 1st St.

Wilmington, Delaware

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300 West 1st St.

Wilmington, Delaware  
Fuller House  
300 West 1st St.

50 5851

50 5851

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

c. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

a. STATE

Maryland

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

20-06

d. STREET ADDRESS (If rural, give location)

2801 Sunset Drive

8. DATE OF BIRTH

Aug. 13, 1901

9. AGE (In years last birthday)

48

If Under 1 Year

Months

Days

If Under 24 Hours

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work log life, even if retired)

Sheet Metal

10b. KIND OF BUSINESS OR INDUSTRY

Westinghouse Elec.

11. BIRTHPLACE (State or foreign country)

Ireland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Michael Manning

14. MOTHER'S MAIDEN NAME

Catherine Moriarty

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Katherine Manning 2801 Sunset Dr.

18. 420.1

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Acute Coronary Occlusion

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

10 minutes

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Acute Coronary Insufficiency

DUE TO

(C)

Over Activity

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at 2:35 p. m., from the causes and on the date stated above.

23a. SIGNATURE

William Conway

23b. ADDRESS

M. O.

Stagnes Hosp. Baltimore 29

23c. DATE SIGNED

7/2/50

24a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24b. DATE

7/5/50

24c. NAME OF CEMETERY OR CREMATORY

ST. MICHAELS

24d. LOCATION (City, town, or county)

Springfield, Mass

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

M. Faher &amp; Sons 1827 W. North Ave.

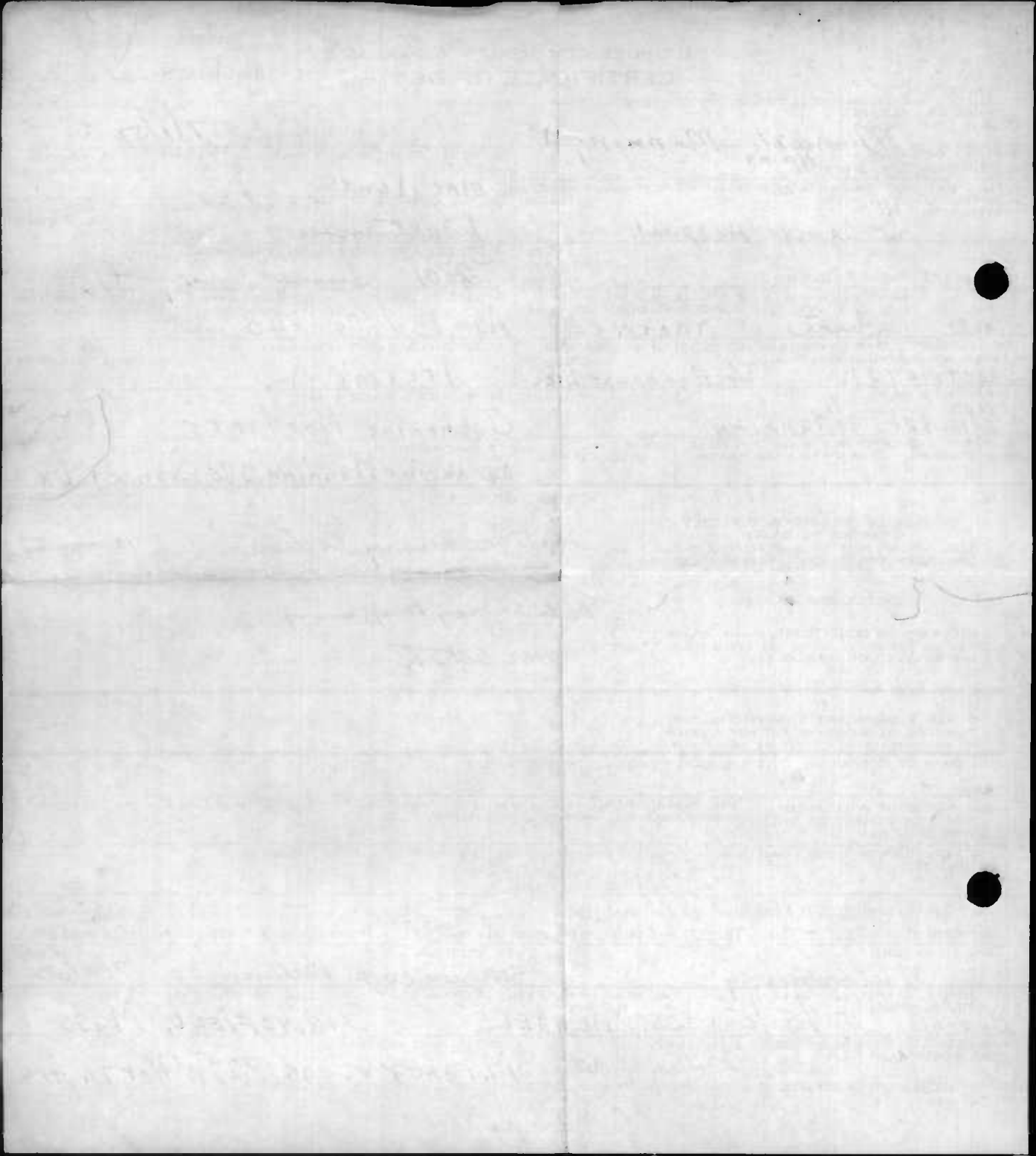
HL 3-1950

VS 150

5913M

94a

MEDICAL CERTIFICATION



D-620

50 5852

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

50 5852

1. NAME OF DECEASED  
(Type or Print)

JAMES DORSEY

2. DATE  
OF  
DEATH

JUNE 30, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

Doctors Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1313 Wohler Way #24

C. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

MALE

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Unemployed MACH. HELPER SHIP REPAIRS

13. FATHER'S NAME

Eugene Clement Dorsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

8. DATE OF BIRTH

March 28, 1928

9. AGE (In years last birthday)

22

11 Under 1 Year Months: Days: Hours: Min.

11. BIRTHPLACE (State or foreign country)

Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

14. MOTHER'S MAIDEN NAME

Lola Louise Albright

17. INFORMANT

Lola L. Dorsey

ADDRESS

1313 Wohler Way

18. 550.0 002 X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute appendicitis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Pulmonary tuberculosis for about 3 years  
bilateral effusion

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN ONSET AND DEATH

2 days

19A. DATE OF OPERATION

6/28/50 @ 1:00 PM

19B. MAJOR FINDINGS OF OPERATION

Dilated appendix, necrotic tissue

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 1947, to June 30, 1950, that I last saw the deceased alive on June 30, 1950, and that death occurred at 9:02 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Benjamin S. Siegel

23B. ADDRESS

M. D. 15 Greenwood Rd

23C. DATE SIGNED

6/30/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

Burial July 3, 1950

24C. NAME OF CEMETERY OR CREMATORY

Oaklawn

24D. LOCATION (City, town, or county) (State)

Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

John E. Hoff - Chase, Md.

ADDRESS

- 3 - 1950 VS 150

4964V

121

MEDICAL CERTIFICATION



UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

JAMES H. HARRIS

James H. Harris

G-200  
50 5853

50 5853

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

|  |                                  |  |  |   |   |   |                                  |
|--|----------------------------------|--|--|---|---|---|----------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>BERTRAM B.R. COOK</b>  |                                  |  |  | 2. DATE OF DEATH <b>JULY 3, 1950</b>  |   |   |                                  |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>   |                                  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO.</b> |   |   |                                  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>THE UNION MEMORIAL HOSPITAL</b>   |                                  |  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTIMORE 22-10</b>                                    |   |   |                                  |
| C. Length of stay in Baltimore   |                                  |  |  | D. STREET ADDRESS (If rural, give location)<br><b>725 E. COLDSRING LANE</b>   |   |   |                                  |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>MARRIED</b>                        | 8. DATE OF BIRTH<br><b>FEB. 26, 1885</b>   |   | 9. AGE (In years last birthday)<br><b>65</b>                | 10. Under 1 Year: Months: Days: 11. Under 24 Hours: Hours: Min.       |                                  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SUPT. D. CHILDREN'S HOME, BALTO. - RETIRED</b>   |                                  |  | 10B. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)<br><b>ENGLAND</b> |   |                                  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                  |  | 13. FATHER'S NAME<br><b>WILLIAM COOK</b>   |   |   |   |                                  |
| 14. MOTHER'S MAIDEN NAME<br><b>SARAH FISHER</b>  |                                  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b> |   |   |   |                                  |
| 16. SOCIAL SECURITY NO.  |                                  |  | 17. INFORMANT ADDRESS<br><b>MRS. COOK (WIFE) 725 E. COLDSRING LANE BALTO.</b>  |   |   |   |                                  |
| 18. CAUSE OF DEATH   |                                  |  |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH |
| I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>CEREBRAL EMBOLISM</b>                                |                                  |  |  |   |   |   | <b>15 minutes</b>                |
| DUE TO   |                                  |  |  |   |   |   |                                  |
| II<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE. (A) STATING THE UNDERLYING CONDITION LAST.<br><b>POLYCYTHEMIA</b>   |                                  |  |  |   |   |   | <b>1 month</b>                   |
| DUE TO   |                                  |  |  |   |   |   |                                  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>CONGESTIVE HEART FAILURE, ARTERIO-SCLEROTIC</b>  |                                  |  |  |   |   |   | <b>1 month</b>                   |
| DUE TO   |                                  |  |  |   |   |   |                                  |
| 19A. DATE OF OPERATION <b>2</b>  |                                  |  |  |   |   |   | 19B. MAJOR FINDINGS OF OPERATION |
| 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  |  |  |   |   |   |                                  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |                                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |   |                                  |
| 22. TIME (Month) (Day) (Year) (Hour) INJURY  |                                  | 23. INJURY OCCURRED  |  | 24. HOW DID INJURY OCCUR?   |   |   |                                  |
| m.   |                                  | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>        |  |   |   |   |                                  |
| 25. I hereby certify that I attended the deceased from <b>JUNE 10, 1950</b> , to <b>JULY 3, 1950</b> , that I last saw the deceased alive on <b>JULY 3, 1950</b> , and that death occurred at <b>4:50 A.M.</b> , from the causes and on the date stated above. |                                  |  |  |   |   |   |                                  |
| 26A. SIGNATURE<br><b>Alfred S. Nelson</b>  |                                  |  |  | 26B. ADDRESS<br><b>Baltimore 18 Maryland</b>  |   | 26C. DATE SIGNED<br><b>July 3, 1950</b>                               |                                  |
| 27A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  |                                  | 27B. DATE<br><b>7/4/50</b>   |  | 27C. NAME OF CEMETERY OR CREMATORY<br><b>Sylvan Lawn Cem.</b>   |   | 27D. LOCATION (City, town, or county) (State)<br><b>Greene, N. Y.</b> |                                  |
| 28. DATE RECEIVED BY LOCAL REGISTRAR   |                                  | 28. REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b>                                  |  | 29. FUNERAL DIRECTOR<br><b>Wm. J. Gickner &amp; Sons - Balto</b>  |   | 30. ADDRESS<br><b>76B Md.</b>   |                                  |

JUL 3 - 1950

2908W

76B Md.

MEDICAL CERTIFICATION

STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL  
CERTIFICATE OF TITLE

|                               |  |
|-------------------------------|--|
| No. _____                     |  |
| Date of Issuance _____        |  |
| County of _____               |  |
| Town of _____                 |  |
| City of _____                 |  |
| State of _____                |  |
| Name of Owner _____           |  |
| Address _____                 |  |
| City _____                    |  |
| State _____                   |  |
| Description of Property _____ |  |
| Area _____                    |  |
| Value _____                   |  |
| Tax _____                     |  |
| Assessment _____              |  |
| Remarks _____                 |  |

W-2 00  
50 5854

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5854

Registered No.

BIRTH NO.

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>James J. Lacy</b>   |                                  | 2. DATE OF DEATH <b>7/1/50</b>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>Baltimore, Md.</b>   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>3800 Fenchurch Road</b>   |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>                               |  |
| C. Length of stay in Baltimore <b>46</b> Yrs. Mos. Days   |                                  | D. STREET ADDRESS (If rural, give location)<br><b>3800 Fenchurch Road, Guilford</b>  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>  | 8. DATE OF BIRTH<br><b>----</b>  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Executive</b> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Foundry</b>  | 9. AGE (in years last birthday) <b>46</b><br>If Under 1 Year: Months: Days<br>If Under 24 Hours: Hours: Min. |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME<br><b>Joseph J. Lacy</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary F. Collins</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)                             |                                  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT<br><b>Mrs. Rose Lacy</b>  |                                  | ADDRESS<br><b>3800 Fenchurch Road</b>  |  |

|  |  |                                  |
|--|--|----------------------------------|
| 18. <b>420.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Coronary Occlusion</b><br>DUE TO<br>(A) <b>Coronary Occlusion</b><br>(B) <b>10 hours</b><br>(C) |  | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B)<br>(C)   |  |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |                                  |

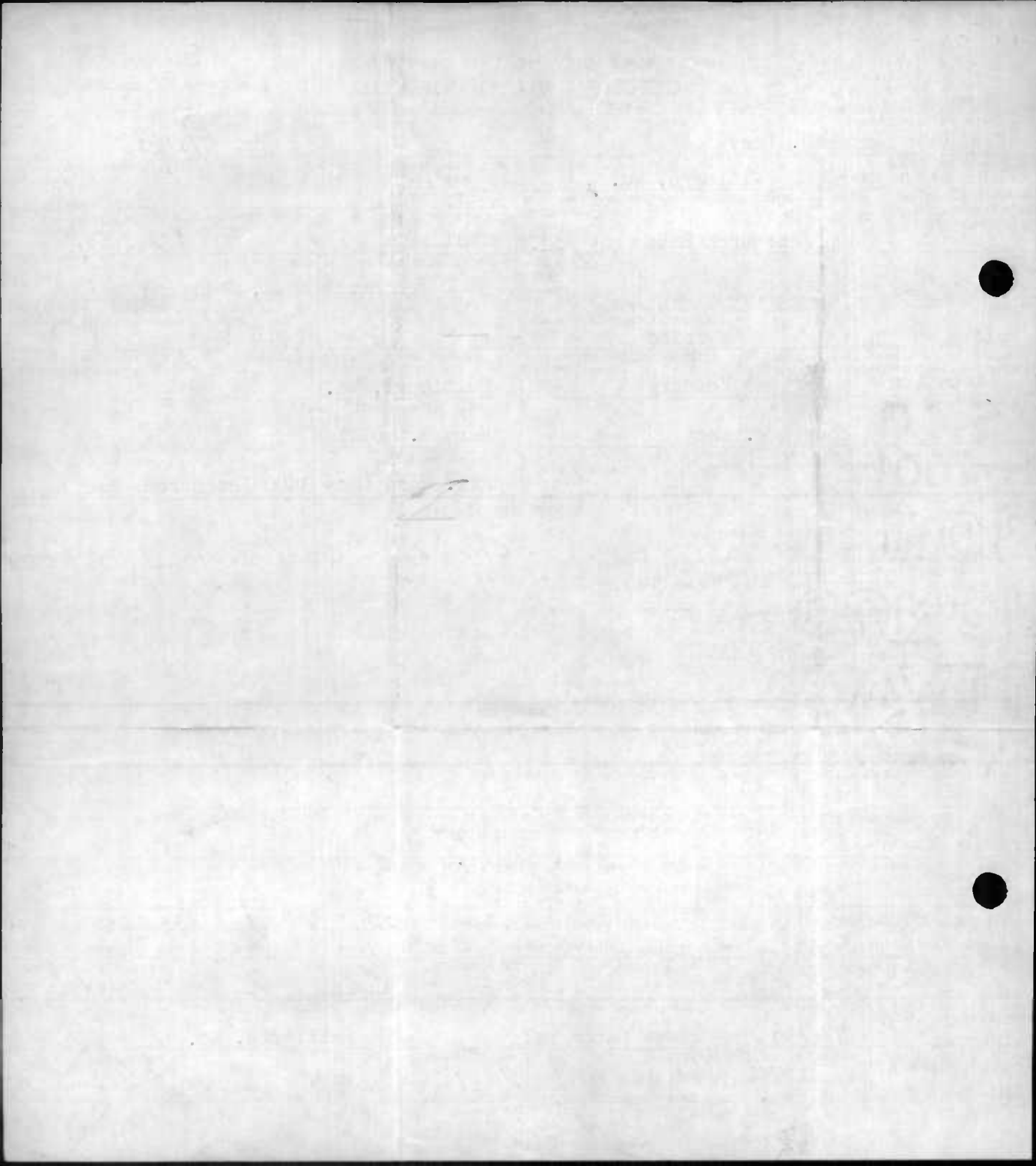
|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 19A. DATE OF OPERATION <b>0</b>   |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <b>6-30</b> , 19 <b>50</b> , to <b>7-1</b> , 19 <b>50</b> ; that I last saw the deceased alive on <b>6-30</b> , 19 <b>50</b> , and that death occurred at <b>8:30 a.m.</b> , from the causes and on the date stated above. |  |   |  |  |  |
| 23A. SIGNATURE<br><b>P. P. Lacy</b>   |  | 23B. ADDRESS<br><b>11 E. Chen St.</b>   |  | 23C. DATE SIGNED<br><b>7/3/50</b>  |  |

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> |  | 24B. DATE<br><b>7/4/50</b>                               |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b> |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b> |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 3-1950</b>      |  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, Md.</b> |  | 25. FUNERAL DIRECTOR<br><b>W. W. Meade and Son</b>         |  | ADDRESS<br><b>805 N. Calvert St.</b>                                   |  |

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94a



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50 5855

DANEKER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 5855

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

2. DATE OF DEATH

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

B. FULL NAME OF HOSPITAL OR INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

19. DATE OF OPERATION

19A. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22. TIME (Month) (Day) (Year) (Hour)

23. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

24. HOW DID INJURY OCCUR?

25. I hereby certify that I attended the deceased from April 1950 to July 2, 1950, that I last saw the deceased alive on July 2, 1950, and that death occurred at 8:45 m., from the causes and on the date stated above.

26. SIGNATURE

27. ADDRESS

28. DATE SIGNED

29. BURIAL, CREMATION, REMOVAL (Specify)

30. DATE

31. NAME OF CEMETERY OR CREMATORY

32. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

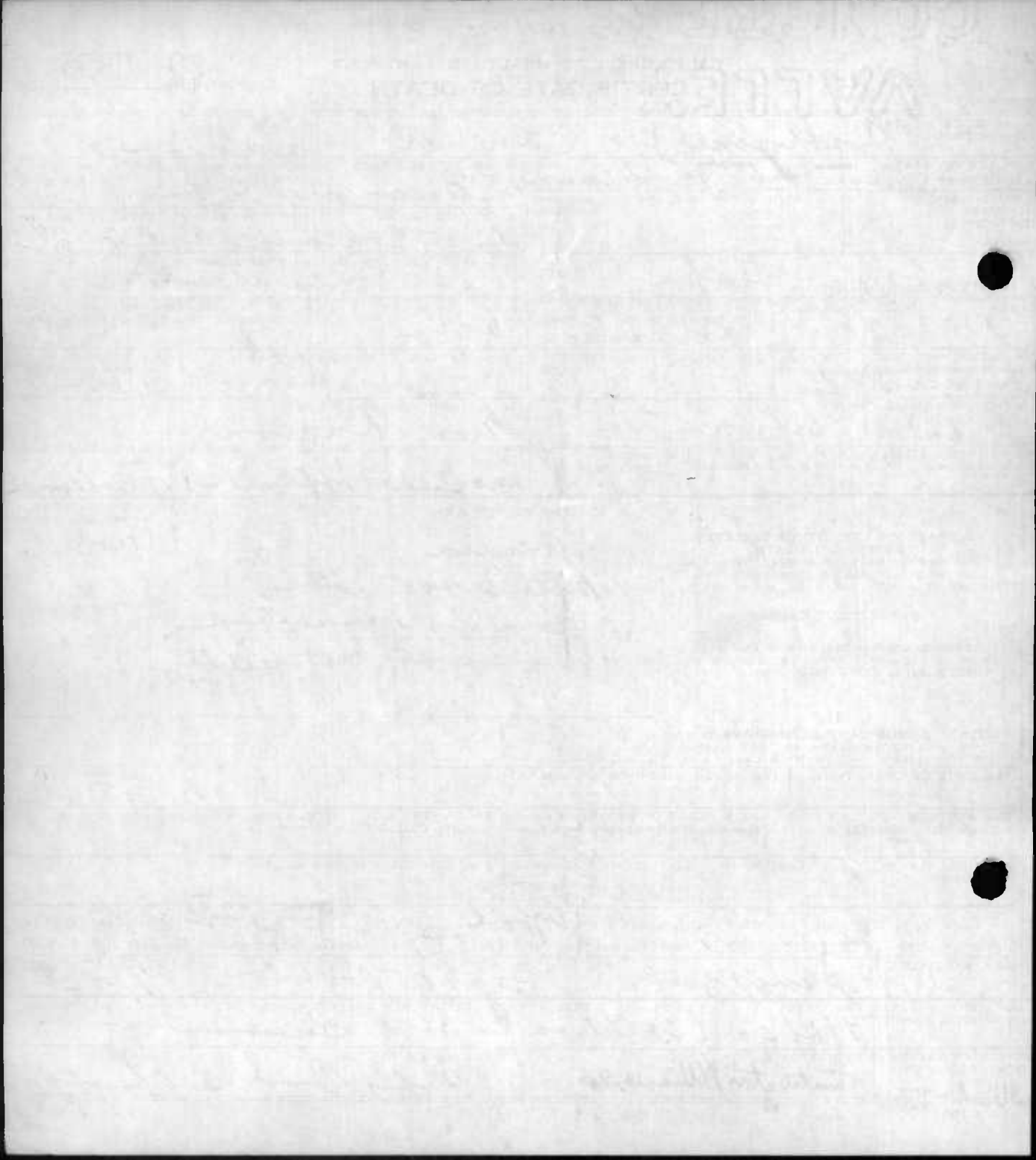
25. FUNERAL DIRECTOR ADDRESS

JUL 4 - 1950

VS 150

937





200

50-5856

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50-5856

BIRTH NO. 50-13230

1. NAME OF DECEASED (Type or Print) **BABY Girl Cook**

2. DATE OF DEATH **July 3 1950**

3. PLACE OF DEATH:  
A. Baltimore City, Maryland **Women's Hospital**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **BALTIMORE MD.**  
B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION **Lafayette and John St BALTO 17 MD**

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**BALTIMORE MD 25-018**

7. STREET ADDRESS (If rural, give location)  
**942 CATON AVE**

8. LENGTH OF STAY IN BALTIMORE **Life**

9. SEX **Female**

10. COLOR OR RACE **White**

11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
**Single**

12. DATE OF BIRTH **July 3 1950**

13. AGE (In years last birthday) **—**

14. Under 1 Year Months: Days **—**

15. Under 24 Hours Hours: Min. **—**

16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
**0 - INFANT**

17. KIND OF BUSINESS OR INDUSTRY **0**

18. BIRTHPLACE (State or foreign country)  
**U. S. A.**

19. CITIZENSHIP OF WHAT COUNTRY?  
**U. S. A.**

20. FATHER'S NAME  
**Irvin Douglas Cook**

21. MOTHER'S MAIDEN NAME  
**Margaret Lee Gruber.**

22. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)  
**No**

23. SOCIAL SECURITY NO.

24. INFORMANT ADDRESS  
**Parent - Margaret Lee Cook**

25. CAUSE OF DEATH

26. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
**(A) Cord around neck (2 x)**  
DUE TO

27. ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  
**(B) Premature Separation Placenta**  
DUE TO **MATERNAL**

28. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  
**(C) Intrapartum Bleeding** **concealed AND external**

29. DATE OF OPERATION **—**

30. MAJOR FINDINGS OF OPERATION **—**

31. AUTOPSY?  
YES ☐ NO ☒

32. 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  
**None**

33. 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  
**In utero**

34. 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  
**In utero**

35. 21D. TIME (Month) (Day) (Year) (Hour) INJURY  
**July 3 1950 m.**

36. 21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

37. 21F. HOW DID INJURY OCCUR?  
**—**

38. 22. I hereby certify that I attended the deceased from **July 3**, 19**50**, to **July 3**, 19**50**, that I last saw the deceased alive on **July 3**, 19**50**, and that death occurred at **07 AM.**, from the causes and on the date stated above.

39. 23A. SIGNATURE  
**Dr. E. Radan**

40. 23B. ADDRESS  
**15 W. Mt. Vernon Pl. BALTO**

41. 23C. DATE SIGNED  
**July 3 1950**

42. 24A. BURIAL, CREMATION, REMOVAL (Specify)  
**Rural**

43. 24B. DATE  
**July 4 1950**

44. 24C. NAME OF CEMETERY OR CREMATORY  
**Woodlawn**

45. 24D. LOCATION (City, town, & county) (State)  
**Woodlawn, Md.**

46. DATE RECEIVED BY LOCAL REGISTRAR

47. REGISTRAR'S SIGNATURE  
**Dr. J. Williams, M.D.**

48. FUNERAL DIRECTOR  
**Wm. Cook**

49. ADDRESS  
**1217 St Paul St BALTO**

50. VS 150  
**JUL 3 - 1950**

51. 160c **md**

CONFIDENTIAL

263

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5857  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)*George A. Reckard*2. DATE  
OF  
DEATH*7/1/50 7 P.M.*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION *Good Samaritan Nursing Home**27 N. Carey St.*

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

*Male*

6. COLOR OR RACE

*White*7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)*Widowed*10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)*Metal Worker*10B. KIND OF BUSINESS OR  
INDUSTRY*Own Business*

13. FATHER'S NAME

*John W. Reckard*15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If yes, give war or dates of service)*No*16. SOCIAL  
SECURITY NO.*Carroll M. Co. 117 Wood Heights Ave*18. *420.1* *199.1* CAUSE OF DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

*Coronary thrombosis*

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

*Arteriosclerotic cardio-  
vascular disease with  
myocardial degeneration*

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.*Possible malignancy, abdominal.*INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *25 April*, 19*50*, to *1 July*, 19*50*, that I last saw the  
deceased alive on *30 June*, 19*50*, and that death occurred at *7 P* m., from the causes and on the date stated above.

23A. SIGNATURE

*Emil H. Henning Jr.*

23B. ADDRESS

*601 Winans Way*

23C. DATE SIGNED

*3 July 50*24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)*Burial*

24B. DATE

*7/5/50*

24C. NAME OF CEMETERY OR CREMATORY

*London Park*

24D. LOCATION (City, town, or county)

*Balto. Md.*DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Huntington Williams, M.D.*

25. FUNERAL DIRECTOR

*Wm. Cook Inc. 1217 St. Paul St.*

ADDRESS

WESTERN  
CENTRAL OF ILLINOIS

*[Faint, illegible text, likely bleed-through from the reverse side of the page. The text appears to be organized into several paragraphs and possibly a table or list structure.]*

460

Galler

0 5858

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5858

Registered No.

|  |                                  |   |   |  |  |
|--|----------------------------------|---|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Nathan Galler</i>  |                                  |   | 2. DATE OF DEATH <i>July 3, 50</i>  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Ind.</i> B. COUNTY |  |  |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>JOHNS HOPKINS HOSPITAL</i>   |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 13-04</i>                  |  |  |
| 6. Length of stay in Baltimore <i>35 YRS.</i>  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><i>2306 Bryant Ave</i>   |  |  |
| 5. SEX<br><i>Male</i>  | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Married</i> | 8. DATE OF BIRTH<br><i>4-6-09</i>   |  | 9. AGE (In years last birthday)<br><i>41</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Chauffeur</i>  |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Taxi Cab</i>              | 11. BIRTHPLACE (State or foreign country)<br><i>Russia</i>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA.</i>  |
| 13. FATHER'S NAME<br><i>Morris Galler</i>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><i>Eva?</i>   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><i>Yes, no or unknown</i> |                                  | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS<br><i>JOHNS HOPKINS HOSPITAL</i> |  |

|  |  |  |  |                                  |  |
|--|--|--|--|----------------------------------|--|
| 18. <i>59 x</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) |  | CAUSE OF DEATH   |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| ANTECEDENT CAUSES  |  | (A) <i>Hemorrhage from left Middle Cerebral Artery</i> |  | <i>3d</i>                        |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  | (B) <i>Hypertension</i>                                |  | <i>1-8 yrs</i>                   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  | (C) <i>Chronic Glomerulonephritis</i>                  |  | <i>14 yrs</i>                    |  |

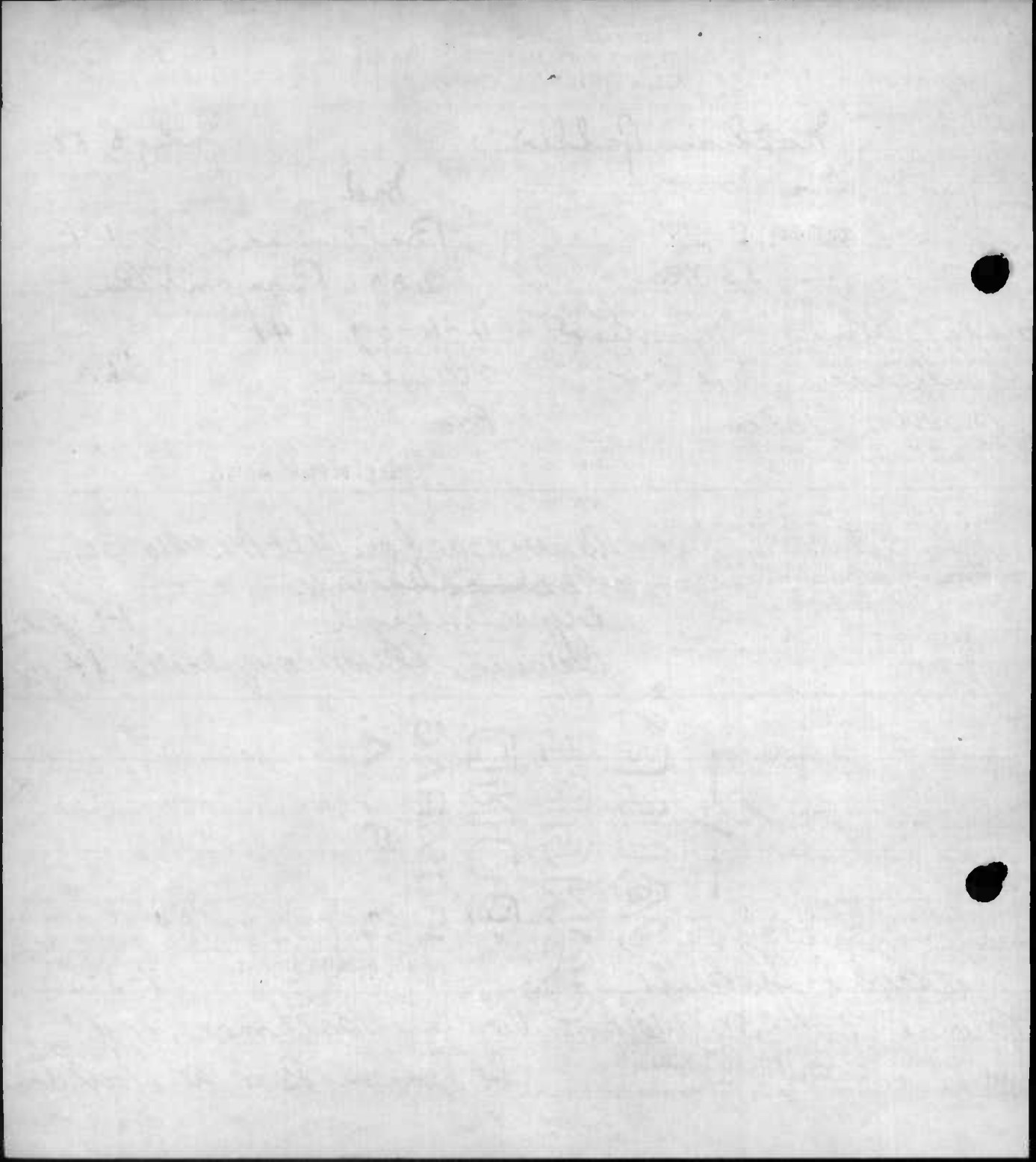
|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 19A. DATE OF OPERATION <i>0</i>   |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br><i>INJURY</i>  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <i>July 1, 1950</i> to <i>July 3, 1950</i> that I last saw the deceased alive on <i>July 3, 1950</i> and that death occurred at <i>11:20</i> m., from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE<br><i>David Lubens</i>   |  | 23B. ADDRESS<br><i>JOHNS HOPKINS HOSPITAL</i>   |  | 23C. DATE SIGNED<br><i>7-3-50</i>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  | 24B. DATE<br><i>7-4-50</i>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Workmen Circle</i>                         |  |
| 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore, Md.</i>  |  | 24E. NAME OF CEMETERY OR CREMATORY<br><i>Workmen Circle</i>   |  | 24F. LOCATION (City, town, or county) (State)<br><i>Baltimore, Md.</i>              |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUL 4 - 1950</i>   |  | REGISTRAR'S SIGNATURE<br><i>Wilmington Williams, Md.</i>  |  | 25. FUNERAL DIRECTOR<br><i>Sol. Levinson &amp; Bros W. North Ave</i>                |  |

VS 150

68254

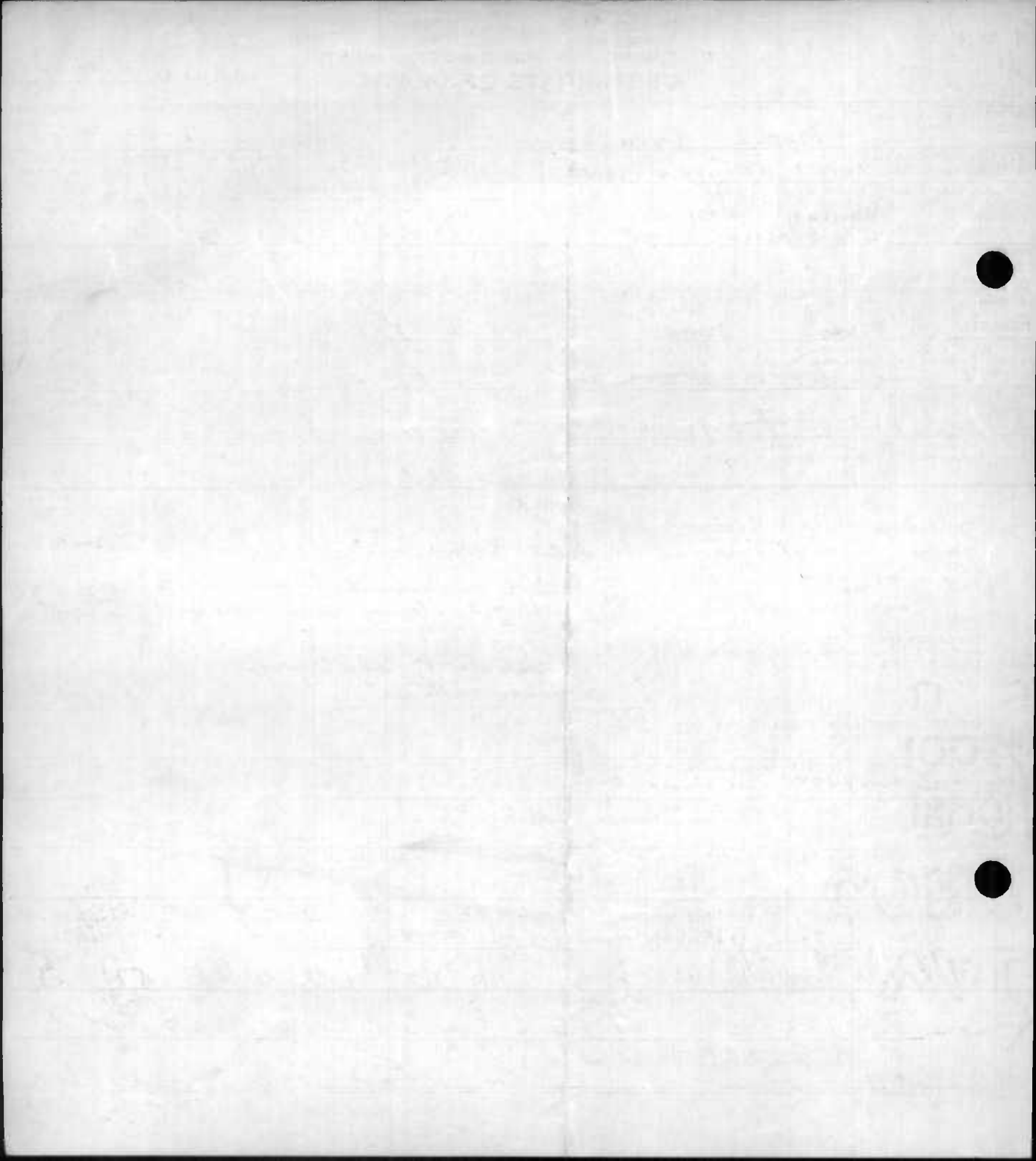
131a





|   |  |
|---|--|
| <div style="font-size: 2em; float: left; margin-right: 10px;">160</div> <div style="text-align: right;"> <div style="display: inline-block; text-align: center;"> <div style="border: 1px solid black; padding: 2px;">50</div> <div style="border: 1px solid black; padding: 2px;">5859</div> </div> <div style="display: inline-block; text-align: center; margin-left: 10px;"> <div style="border: 1px solid black; padding: 2px;">50</div> <div style="border: 1px solid black; padding: 2px;">5859</div> </div> </div>  |  |
| <div style="display: flex; justify-content: space-between;"> <span>BIRTH NO.</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> <span>Registered No.</span> </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div>   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <span style="float: right;">2. DATE OF DEATH</span>  |  |
| <span style="font-size: 1.5em;">MABLE DUPREE</span> <span style="float: right; font-size: 1.5em;">7-3-50</span>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <span style="float: right;">4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</span>  |  |
| <span style="font-size: 1.5em;">PROVIDENT Hospital</span> <span style="float: right; font-size: 1.5em;">Maryland Cecil</span>   |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><span style="font-size: 1.5em;">PROVIDENT Hospital</span>   |  |
| <span style="font-size: 1.5em;">1514 Division Street</span>   |  |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><span style="font-size: 1.5em;">North East 5700</span>  |  |
| D. STREET ADDRESS (If rural, give location)<br><span style="font-size: 1.5em;">Washington St - Box 132</span>   |  |
| E. LENGTH OF STAY IN BALTIMORE<br>Yrs. Mos. Days  |  |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><span style="font-size: 1.5em;">Female NEGRO Married</span>  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.5em;">Housewife</span>   |  |
| 10B. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?<br><span style="font-size: 1.5em;">Kenneth Square, Pa U.S.A</span>   |  |
| 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME<br><span style="font-size: 1.5em;">George Ferguson Mary Young</span>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO.<br><span style="font-size: 1.5em;">Mr. William J. Dupree - North East, Md</span>   |  |
| 17. INFORMANT ADDRESS<br><span style="font-size: 1.5em;">Mr. William J. Dupree - North East, Md</span>  |  |
| 18. <span style="font-size: 1.5em;">716 X</span> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(THIS DOES NOT MEAN THE MODE OF DYING, E. G., HEART FAILURE, ASTHENIA, ETC. IT MEANS THE DISEASE, INJURY OR COMPLICATION WHICH CAUSED DEATH.)<br><span style="font-size: 1.5em;">Secondary Shock</span><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><span style="font-size: 1.5em;">(A) Partial Mechanical Obstruction of Small gut - Ileum, Post-operative</span><br><span style="font-size: 1.5em;">(B) Dermoid Cyst, Left Ovary -</span><br><span style="font-size: 1.5em;">(C) Nodular Ectenues</span><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  |
| 19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY?<br><span style="font-size: 1.5em;">6-14-50, 6-29-50</span> <span style="font-size: 1.5em;">See above B &amp; C</span> <span style="font-size: 1.5em;">YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></span>   |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><span style="font-size: 1.5em;">21D. TIME (Month) (Day) (Year) (Hour) INJURY</span> <span style="font-size: 1.5em;">21E. INJURY OCCURRED</span> <span style="font-size: 1.5em;">21F. HOW DID INJURY OCCUR?</span>  |  |
| 22. I hereby certify that I attended the deceased from <span style="font-size: 1.5em;">6-12</span> , 19 <span style="font-size: 1.5em;">50</span> , to <span style="font-size: 1.5em;">7-3</span> , 19 <span style="font-size: 1.5em;">50</span> , that I last saw the deceased alive on <span style="font-size: 1.5em;">7-3</span> , 19 <span style="font-size: 1.5em;">50</span> , and that death occurred at <span style="font-size: 1.5em;">10:20 a.m.</span> , from the causes and on the date stated above.   |  |
| 23A. SIGNATURE 23B. ADDRESS 23C. DATE SIGNED<br><span style="font-size: 1.5em;">Henry B. McCombe</span> <span style="font-size: 1.5em;">1106 Harlem Ave</span> <span style="font-size: 1.5em;">7/3/50</span>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) (State)<br><span style="font-size: 1.5em;">Burial</span> <span style="font-size: 1.5em;">7-6-50</span> <span style="font-size: 1.5em;">St. Marks Cemetery</span> <span style="font-size: 1.5em;">Elk Neck, Md.</span>  |  |
| DATE RECEIVED BY LOCAL REGISTRAR REGISTRAR'S SIGNATURE 25. FUNERAL DIRECTOR ADDRESS<br><span style="font-size: 1.5em;">JUL 4 - 1950</span> <span style="font-size: 1.5em;">Thurston Williams, M.D.</span> <span style="font-size: 1.5em;">Eugene E. Bullock</span> <span style="font-size: 1.5em;">Harrods-Grac.</span>   |  |
| <span style="font-size: 2em;">56E</span> <span style="font-size: 1.5em;">mb.</span>   |  |

MEDICAL CERTIFICATION



245  
50 5860BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5860  
Registered No.

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>MARY EVA RESELING</b>  |                                  | 2. DATE OF DEATH <b>July 2, 1950</b>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>2322 W. Fayette St.</b>  |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTIMORE 20-02</b>                         |  |
| C. Length of stay in Baltimore <b>LIFE</b>   |                                  | D. STREET ADDRESS (If rural, give location)<br><b>2322 W. Fayette St.</b>  |  |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widow</b>  | 8. DATE OF BIRTH<br><b>June 20, 1868</b> |
| 9. AGE (In years last birthday)<br><b>82</b>   |                                  | 10. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Gottlieb Fischer</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Gertrude Schmidt</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>NONE</b>   |  |
| 17. INFORMANT<br><b>Frances Reseling</b>   |                                  | ADDRESS<br><b>2322 W Fayette St.</b>   |  |
| 18. <b>4-2-2</b> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Myocarditis, Chronic</b><br>DUE TO<br>(A) <b>Serility</b><br>(B) <b>Serility</b><br>DUE TO<br>(C) <b>Serility</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>6 mo.</b> |                                  |  |  |
| 19. DATE OF OPERATION <b>0</b> 19B. MAJOR FINDINGS OF OPERATION  |                                  |  |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |  |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                                      |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                                  | 21D. TIME (Month) (Day) (Year) (Hour)  |  |
| 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                                  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <b>June 16, 1950</b> to <b>July 2, 1950</b> , that I last saw the deceased alive on <b>July 2, 1950</b> and that death occurred at <b>8:30 A. M.</b> , from the causes and on the date stated above.  |                                  |  |  |
| 23A. SIGNATURE<br><b>J. Lloyd Johnson</b>  |                                  | 23B. ADDRESS<br><b>Catonville, Md.</b>   |  |
| 23C. DATE SIGNED<br><b>7/3/50</b>  |                                  | 23D. DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 4-1950</b>   |  |
| 23E. REGISTRAR'S SIGNATURE<br><b>James H. Williams, M.D.</b>   |                                  | 23F. FUNERAL DIRECTOR<br><b>George L. Schwab</b>   |  |
| 23G. ADDRESS<br><b>2101 Frederick Ave.</b>   |                                  | 23H. ADDRESS<br><b>937 Ave.</b>  |  |

CERTIFICATE OF DEATH

1. Name of deceased: *John Doe*  
2. Sex: *Male*  
3. Age: *45*  
4. Date of death: *10/15/1950*  
5. Place of death: *Home*  
6. Cause of death: *Heart Disease*  
7. Signature of physician: *Dr. J. Smith*  
8. Signature of registrar: *John Doe*  
9. Date of registration: *10/15/1950*  
10. Place of registration: *City of New York*

525

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5861

Registered No.

BIRTH NO. 5861

|   |                            |  |  |  |  |
|---|----------------------------|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <u>Bertha Lenora Johnson</u>   |                            |  | 2. DATE OF DEATH <u>July 2, 1950</u>   |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                            |  | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <u>Md.</u><br>B. COUNTY <u>11-04</u> |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><u>St. Joseph's</u>                 |                            |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><u>Baltimore</u>                                       |  |  |
| C. Length of stay in Baltimore<br>Yrs. <u>0</u><br>Mos. <u>0</u><br>Days <u>0</u>   |                            |  | D. STREET ADDRESS (If rural, give location)<br><u>1312 Eutaw Place</u>   |  |  |
| 5. SEX <u>F.</u>  | 6. COLOR OR RACE <u>W.</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Married</u>      | 8. DATE OF BIRTH<br><u>Oct. 29 - 1879</u>  |  | 9. AGE (In years last birthday) <u>70</u>  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Wife &amp; Seamstress</u> |                            | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home &amp; Goldman Co.</u> | 11. BIRTHPLACE (State or foreign country)<br><u>Baltimore</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u> |
| 13. FATHER'S NAME<br><u>John Henry Marsheck</u>   |                            |  | 14. MOTHER'S MAIDEN NAME<br><u>Minnie Wolf</u>   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><u>No.</u>   |                            |  | 16. SOCIAL SECURITY NO.<br><u>216-07-3678</u>  |  |  |
| 17. INFORMANT<br><u>Calvin E. Johnson</u>   |                            |  | ADDRESS<br><u>Same</u>   |  |  |

|  |   |  |   |                                     |
|--|---|--|---|-------------------------------------|
| 18. <u>15-0X</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |   | CAUSE OF DEATH<br>(A) <u>aspiration stroke brain &amp; pulmonary</u><br>DUE TO<br>(B) <u>infection</u><br>DUE TO<br>(C) <u>Post-op. Esophageal resection for Carcinoma</u> |   | INTERVAL BETWEEN ONSET AND DEATH    |
| 19A. DATE OF OPERATION<br><u>June 30, 1950</u>   | 19B. MAJOR FINDINGS OF OPERATION<br><u>Carcinoma, esophagus</u>   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                     |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |   |                                     |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>INJURY  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |                                     |
| 22. I hereby certify that I attended the deceased from <u>June 17, 1950</u> , to <u>July 2, 1950</u> , that I last saw the deceased alive on <u>July 2, 1950</u> , and that death occurred at <u>1:15 p.m.</u> , from the causes and on the date stated above.   |   |  |   |                                     |
| 23A. SIGNATURE<br><u>William A. Rogers</u>   | M. D.   | 23B. ADDRESS<br><u>1100 N. Caroline St.</u>  | 23C. DATE SIGNED<br><u>July 2, 1950</u>   |                                     |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   | 24B. DATE<br><u>JULY 5-50</u>   | 24C. NAME OF CEMETERY OR CREMATORY<br><u>HOLLY REDEEMER CEM?</u>   | 24D. LOCATION (City, town, or county) (State)<br><u>BALTIMORE MARYLAND</u>          |                                     |
| DATE RECEIVED BY LOCAL REGISTRAR<br><u>JUL 4 - 1950</u>  | REGISTRAR'S SIGNATURE<br><u>Wm. A. Rogers</u>   | 25. FUNERAL DIRECTOR<br><u>F. Blumenthal &amp; Son</u>   |   | ADDRESS<br><u>1300 Eutaw Pl. 17</u> |



UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

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412  
5862BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5862

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

SADIE PHILLIPS

2. DATE  
OF DEATH July 1, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

Franklin Square Hospital

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Female

Colored

widowed

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

H. W.

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

James Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

(Yes, no or unknown)

16. SOCIAL SECURITY NO.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
MarylandC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
BaltimoreD. STREET ADDRESS (If rural, give location)  
262 N. Bruce Street

8. DATE OF BIRTH

Feb. 22, 1895

9. AGE (in years last birthday)

55

11 Under 1 Year Months Days

11 Under 24 Hours Hours Min.

11. BIRTHPLACE (State or foreign country)

Calvert Co., Maryland

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Nancy Bloom

17. INFORMANT

ADDRESS

Lawrence Jones, 262 N. Bruce Street

18.

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED WHILE AT ☐ NOT WHILE ☐ WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
MEDICAL INVESTIGATOR.....23C. DATE SIGNED  
7-1-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

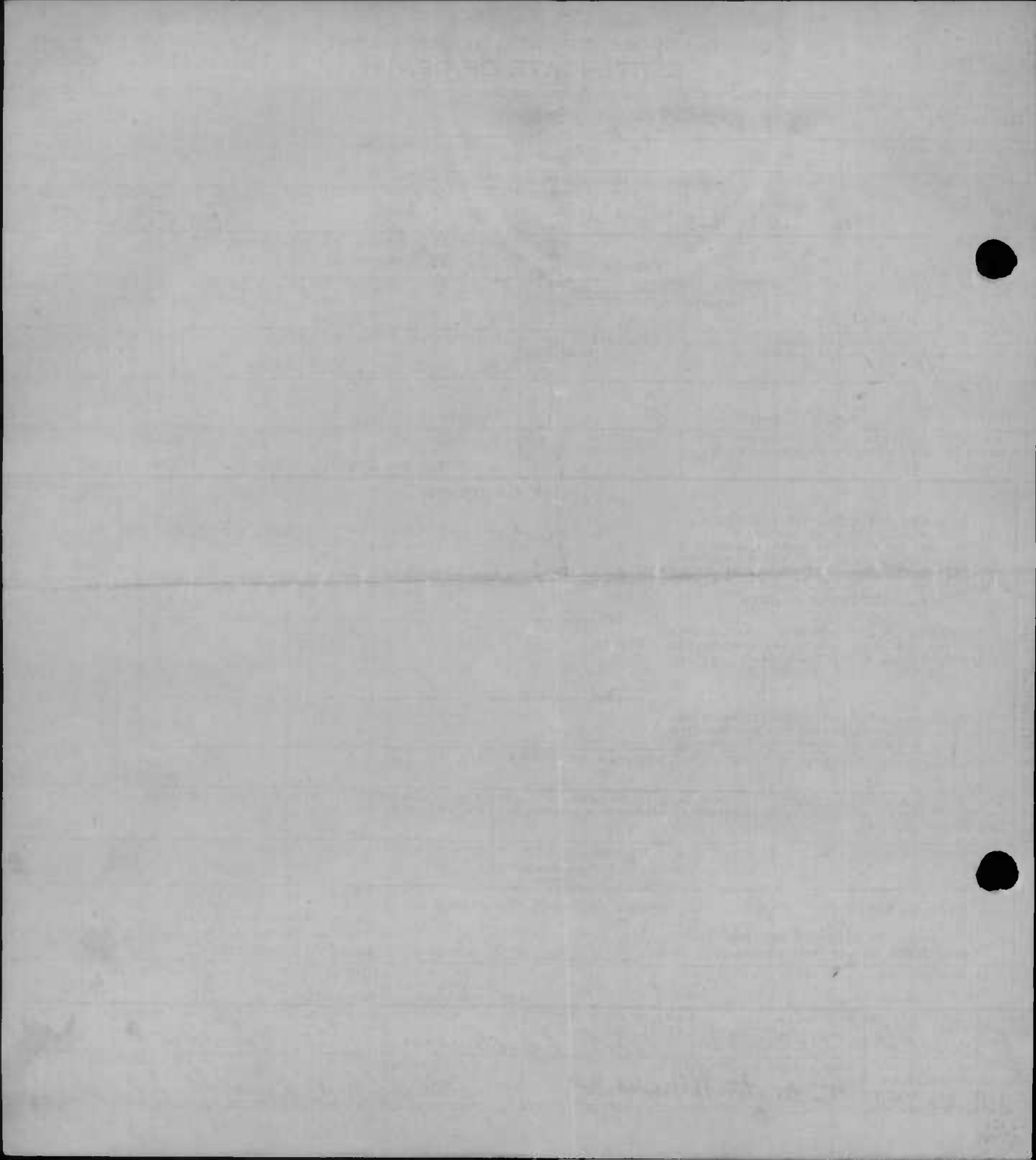
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



600

50 5863

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5863

|   |                                 |   |  |
|---|---------------------------------|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>MORRIS, SHEER</b>   |                                 | 2. DATE OF DEATH <b>7-3-50</b>  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>4613 Park Heights</b>  |                                 | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD</b> B. COUNTY |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Mt Sinai Home</b>  |                                 | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 15-13</b>                   |  |
| C. Length of stay in Baltimore <b>47</b> Yrs. <del>Months</del> <del>Days</del>   |                                 | D. STREET ADDRESS (If rural, give location) <b>4128 Dunbar Road</b>   |  |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>(White)</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>  | 8. DATE OF BIRTH                                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>   |                                 | 10B. KIND OF BUSINESS OR INDUSTRY   |  |
| 13. FATHER'S NAME <b>Hyman</b>  |                                 | 14. MOTHER'S MAIDEN NAME <b>Sarah</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>   |                                 | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT <b>Rosie Sheer</b>  |                                 | ADDRESS <b>Danville</b>   |  |
| 18. <b>153 X I</b> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>(A) Adenocarcinoma of Colon with Metastasis</b><br>DUE TO<br><b>(B)</b><br>DUE TO<br><b>(C)</b> |                                 |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>15 months</b> |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                                 |   |  |
| 19A. DATE OF OPERATION <b>April 1950</b>  |                                 | 19B. MAJOR FINDINGS OF OPERATION <b>Adenocarcinoma of large bowel</b>   |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                 |   |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                                 | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                              |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                                 |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |                                 | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK                |  |
| 21F. HOW DID INJURY OCCUR?  |                                 |   |  |
| 22. I hereby certify that I attended the deceased from <b>Jan 1949</b> , to <b>July 3, 1950</b> , that I last saw the deceased alive on <b>July 3, 1950</b> , and that death occurred at <b>10-17 a.m.</b> , from the causes and on the date stated above.  |                                 |   |  |
| 23A. SIGNATURE <b>Danville Ashworth</b>   |                                 | 23B. ADDRESS <b>2320 Eutan Place</b>  |  |
| 23C. DATE SIGNED <b>July 4, 1950</b>  |                                 |   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                                 | 24B. DATE <b>July 4, 1950</b>   |  |
| 24C. NAME OF CEMETERY OR CREMATORY <b>Mt Carmel</b>   |                                 | 24D. LOCATION (City, town or county) <b>Balto Md.</b>   |  |
| DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 4 - 1950</b>  |                                 | REGISTRAR'S SIGNATURE <b>Thurston Williams, Md</b>  |  |
| FUNERAL DIRECTOR <b>John Lewis, Jr - 2101 Eutan Pl.</b>   |                                 | ADDRESS   |  |

Rehman  
2320 bataul PL

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455  
5864

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5864

|  |                               |   |                  |  |  |
|--|-------------------------------|---|------------------|--|--|
| BIRTH NO.  |                               | 1. NAME OF DECEASED<br>(Type or Print) <b>BERTHA BHUMENSTIEL</b>  |                  | 2. DATE OF DEATH <b>7-3-50</b>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                               | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Md</b> B. COUNTY |                  |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>7354 Centaw Place</b>   |                               | C. CITY OR TOWN (If outside corporate limits, write FULL NAME and give township) <b>Baltimore 13-03</b>               |                  |  |  |
| C. Length of stay in Baltimore <b>9</b> Yrs. <b>Mo.</b> <b>Days</b>  |                               | D. STREET ADDRESS (If rural, give location) <b>2354 Centaw Place</b>  |                  |  |  |
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>  | 8. DATE OF BIRTH | 9. AGE (In years last birthday) <b>86</b>                                | 10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>   |                               | 10B. KIND OF BUSINESS OR INDUSTRY   |                  | 11. BIRTHPLACE (State or foreign country) <b>Germany</b>                 |  |
| 13. FATHER'S NAME <b>Isaac Nustbaum</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>Karoline</b>  |                  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |                               | 16. SOCIAL SECURITY NO.   |                  | 17. INFORMANT ADDRESS <b>Frederick Goodsmith - Same</b>                  |  |
| 18. <b>420.1.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Coronary thrombosis</b><br><b>coronary sclerosis</b> |                               | (A) DUE TO  |                  | (B) DUE TO   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>II</b>  |                               | (C)   |                  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| 19A. DATE OF OPERATION <b>0</b>  |                               | 19B. MAJOR FINDINGS OF OPERATION  |                  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |                               | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                             |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   |                               | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>             |                  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <b>7-3-50</b> to <b>7-3-50</b> , that I last saw the deceased alive on <b>7-3-1950</b> and that death occurred at <b>10:07</b> m. from the causes and on the date stated above.   |                               |   |                  |  |  |
| 23A. SIGNATURE <b>HUNT H. Bix</b>  |                               | 23B. ADDRESS <b>2516 Linden Ave</b>   |                  | 23C. DATE SIGNED <b>7-4-50</b>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Normal</b>  |                               | 24B. DATE <b>7-4-50</b>   |                  | 24C. NAME OF CEMETERY OR CREMATORY <b>Rosedale</b>                       |  |
| 24D. LOCATION (city, town, or county) (State) <b>Batts Md</b>  |                               | 24E. DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 4 - 1950</b>   |                  | 24F. REGISTRAR'S SIGNATURE <b>Huntington Williams, MD</b>                |  |
| 24G. FUNERAL DIRECTOR <b>Jack K...</b>   |                               | 24H. ADDRESS <b>2100 Centaw Pl</b>  |                  | 24I. 94a   |  |

MEDICAL CERTIFICATION



Mr  
Lunden Ave

VALLEY  
CONCRETE  
CO.

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 5865**

BIRTH NO. **50 5865**

|  |                                  |   |  |  |  |
|--|----------------------------------|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>SAMUEL TABB</b>  |                                  |   | 2. DATE OF DEATH <b>July 4, 1950</b>   |  |  |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |  |  |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>West Baltimore General Hospital</b>                        |                                  |   | 6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>                               |  |  |
| 7. STREET ADDRESS (If rural, give location)<br><b>3844 Dolfield Avenue</b>                               |                                  |   | 8. DATE OF BIRTH   |  |  |
| 9. LENGTH OF STAY IN BALTIMORE <b>Life</b>   |                                  |   | 9. AGE (In years last birthday) <b>40</b>  |  |  |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>married</b> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Merchant</b>                  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Balto Md</b> |
| 10A. KIND OF BUSINESS OR INDUSTRY<br><b>Candy Store</b>  |                                  |   | 12. CITIZEN OF WHAT COUNTRY?   |  |  |
| 13. FATHER'S NAME<br><b>Sam Tabachnick</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Dora</b>  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) |                                  |   | 16. SOCIAL SECURITY NO.  |  |  |
| 17. INFORMANT<br><b>Sophie Tabb</b>  |                                  |   | ADDRESS<br><b>Same</b>   |  |  |

|  |  |   |                                  |
|--|--|---|----------------------------------|
| 18. <b>4-20-1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Coronary occlusion</b><br>DUE TO<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  | CAUSE OF DEATH<br>(A) <b>Coronary occlusion</b><br>(B)<br>(C) | INTERVAL BETWEEN ONSET AND DEATH |
|--|--|---|----------------------------------|

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 19A. DATE OF OPERATION  |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) (Minute) INJURY   |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that I took charge of the remains described above, held an <b>autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |  |  |  |   |  |

|  |                            |  |  |   |  |
|--|----------------------------|--|--|---|--|
| 23A. SIGNATURE<br><b>R S Fisher</b>                        |                            | 23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D. MEDICAL INVESTIGATOR <input type="checkbox"/> |  | 23C. DATE SIGNED<br><b>July 4, 1950</b>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24B. DATE<br><b>7-4-50</b> | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Rosedale</b>  | 24D. LOCATION (City, town, or county) (State)<br><b>Balto Md</b> |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 4 - 1950</b>    |                            | REGISTRAR'S SIGNATURE<br><b>Christington Williams, M.D.</b>  |  | 25. FUNERAL DIRECTOR<br><b>Jack Lewis</b> |  |
|  |                            |  |  | ADDRESS<br><b>2100 Eutan Pl</b>           |  |

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]

2. Date of death: [illegible]

3. Place of death: [illegible]

4. Cause of death: [illegible]

5. Name of informant: [illegible]

6. Signature of informant: [illegible]

7. Name of registrar: [illegible]

8. Signature of registrar: [illegible]

9. Name of medical officer: [illegible]

10. Signature of medical officer: [illegible]

11. Name of coroner: [illegible]

12. Signature of coroner: [illegible]

620  
5626  
5866

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5866

|   |  |   |  |  |  |  |  |  |  |  |  |
|---|--|---|--|--|--|--|--|--|--|--|--|
| BIRTH NO.   |  |   |  | 1. NAME OF DECEASED<br>(Type or Print) <b>MARY BRUZGA. (BRUZGRITE)</b>   |  |  |  | 2. DATE OF DEATH <b>7-2-50</b>   |  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland ✓   |  |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |  |  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 18-03</b>      |  |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>821 Hollins St.</b>   |  |   |  | D. STREET ADDRESS (If rural, give location) <b>821 Hollins St.</b>   |  |  |  | c. Length of stay in Baltimore <b>40.</b>  |  |  |  |
| 5. SEX <b>H.</b>  |  | 6. COLOR OR RACE <b>W.</b>  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>  |  | 8. DATE OF BIRTH <b>2/15/1882</b>                      |  | 9. AGE (In years last birthday) <b>68</b>  |  | If Under 1 Year Months: Days If Under 24 Hours Hours: Min. |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shelving HAND.</b>   |  |   |  | 10B. KIND OF BUSINESS OR INDUSTRY <b>TAILORING</b>   |  |  |  | 11. BIRTHPLACE (State or foreign country) <b>LITHUANIA</b>   |  | 12. CITIZEN OF WHAT COUNTRY?                               |  |
| 13. FATHER'S NAME <b>Jacob. BRUZGA</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME <b>EVA. KARALUTIE</b>   |  |  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) |  |  |  |
| 16. SOCIAL SECURITY NO. <b>217-05-3898</b>  |  |   |  | 17. INFORMANT <b>ROSE PLEDAS</b>   |  |  |  | ADDRESS <b>821 Hollins St.</b>   |  |  |  |
| 18. <b>420.1</b>  |  |   |  | CAUSE OF DEATH   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)   |  |   |  | (A) <b>Coronary Thrombosis</b>   |  |  |  | <b>2 days</b>  |  |  |  |
| ANTECEDENT CAUSES   |  |   |  | (B) <b>Arteriosclerotic Coronary Artery Disease</b>  |  |  |  | <b>?</b>   |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  |   |  | (C)  |  |  |  |  |  |  |  |
| II  |  |   |  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                |  |  |  |  |  |  |  |
| 19A. DATE OF OPERATION <b>0</b>   |  |   |  | 19B. MAJOR FINDINGS OF OPERATION   |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                    |  |  |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  | 21D. TIME (Month) (Day) (Year) (Hour) INJURY           |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?                                 |  |
| 22. I hereby certify that I attended the deceased from <b>June 30, 1950</b> to <b>July 2, 1950</b> , that I last saw the deceased alive on <b>July 2, 1950</b> , and that death occurred at <b>5:30 a. m.</b> , from the causes and on the date stated above. |  |   |  | 23A. SIGNATURE <b>John P. Mulick, Jr.</b>  |  |  |  | 23B. ADDRESS <b>1227 Waver Blvd</b>  |  | 23C. DATE SIGNED <b>7-3-50</b>                             |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 24B. DATE <b>7/5/50</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>  |  | 24D. LOCATION (City, town, or county) <b>Belair Rd</b> |  | 24E. STATE <b>Md.</b>  |  |  |  |
| DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 4 - 1950</b>  |  | REGISTRAR'S SIGNATURE <b>Antington Williams, M.D.</b>                                     |  | 25. FUNERAL DIRECTOR <b>Charles V. Jackson</b>   |  | ADDRESS <b>703 40 Henry</b>                            |  |  |  |  |  |

MEDICAL CERTIFICATION

69046

94a



653  
50 5862 138282BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5867

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Christopher Thornton

2. DATE  
OF  
DEATH

July 3, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street address or location)  
Baltimore City Hospitals  
4940 Eastern Ave.4. USUAL RESIDENCE (Where deceased lived, If institution: residence  
before admission)

A. STATE

B. COUNTY

MD

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1307 Brunt St.-17

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Div.

Yrs.  
Mos.  
Days

B. DATE OF BIRTH

Dec. 25, 1899

9. AGE (In years  
last birthday)

50

# Under 1 Year

Months: Days

# Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

13. FATHER'S NAME

Walter Thornton

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Catherine Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

B. C. H. Records, 4940 Eastern Ave.

18. CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Bronchogenic Carcinoma

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

5-26-50-6-2-50

19B. MAJOR FINDINGS OF OPERATION

Bronchoscopy

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-22-50, 19, to July 3, 1950 that I last saw the  
deceased alive on July 3, 1950, and that death occurred at 6AM m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

M. D.

4940 Eastern Ave.

23C. DATE SIGNED

7-3-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

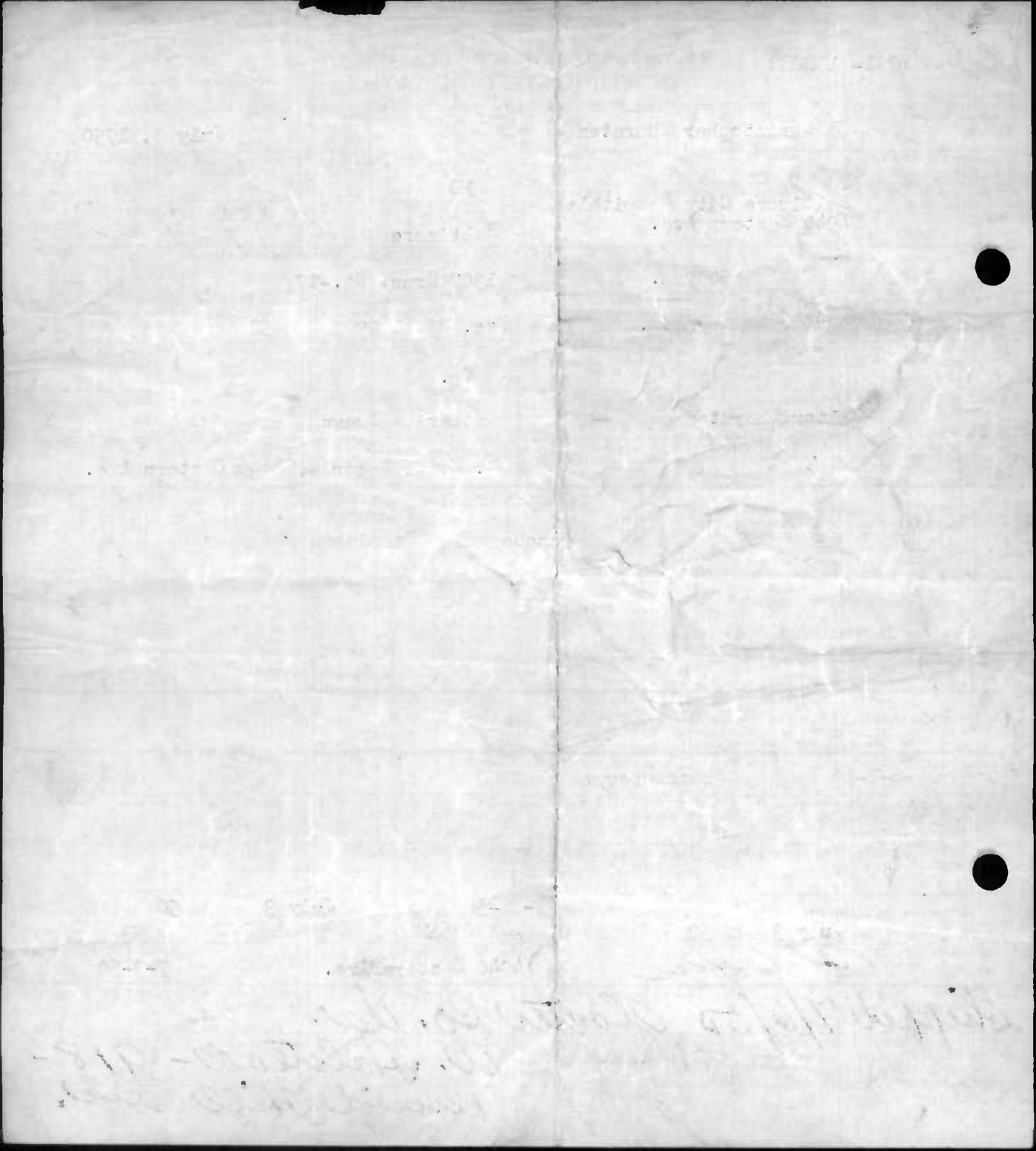
25. FUNERAL DIRECTOR

ADDRESS

VS 150

Shipped 7/6/50  
W. Halstead- 918-  
97099 Almid Hill Ave.  
47c





50 5868

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5868

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Agatha E. Baber. 539993

2. DATE  
OF  
DEATH

JUL 4 - 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

D. C.

V-48

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Washington D.C.

D. STREET ADDRESS (If rural, give location)

1308 E Capital

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female white

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

M.

8. DATE OF BIRTH

10-4-94

9. AGE (In years  
last birthday)

55

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Guy W. Martin

14. MOTHER'S MAIDEN NAME

Mathie Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

None

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 602 X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Renal insufficiency - anuria.

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

June 30/50

19B. MAJOR FINDINGS OF OPERATION

Myocardial infarction, atrophy, uremia, remaining kidney

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-27-1950 to 7-4-1950, that I last saw the  
deceased alive on 7-4-1950, and that death occurred at 5:58 A.M., from the causes and on the date stated above.

23A. SIGNATURE

John T. Grayhark

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

7/4/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/4/50

24C. NAME OF CEMETERY OR CREMATORY

Cedar Hill

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

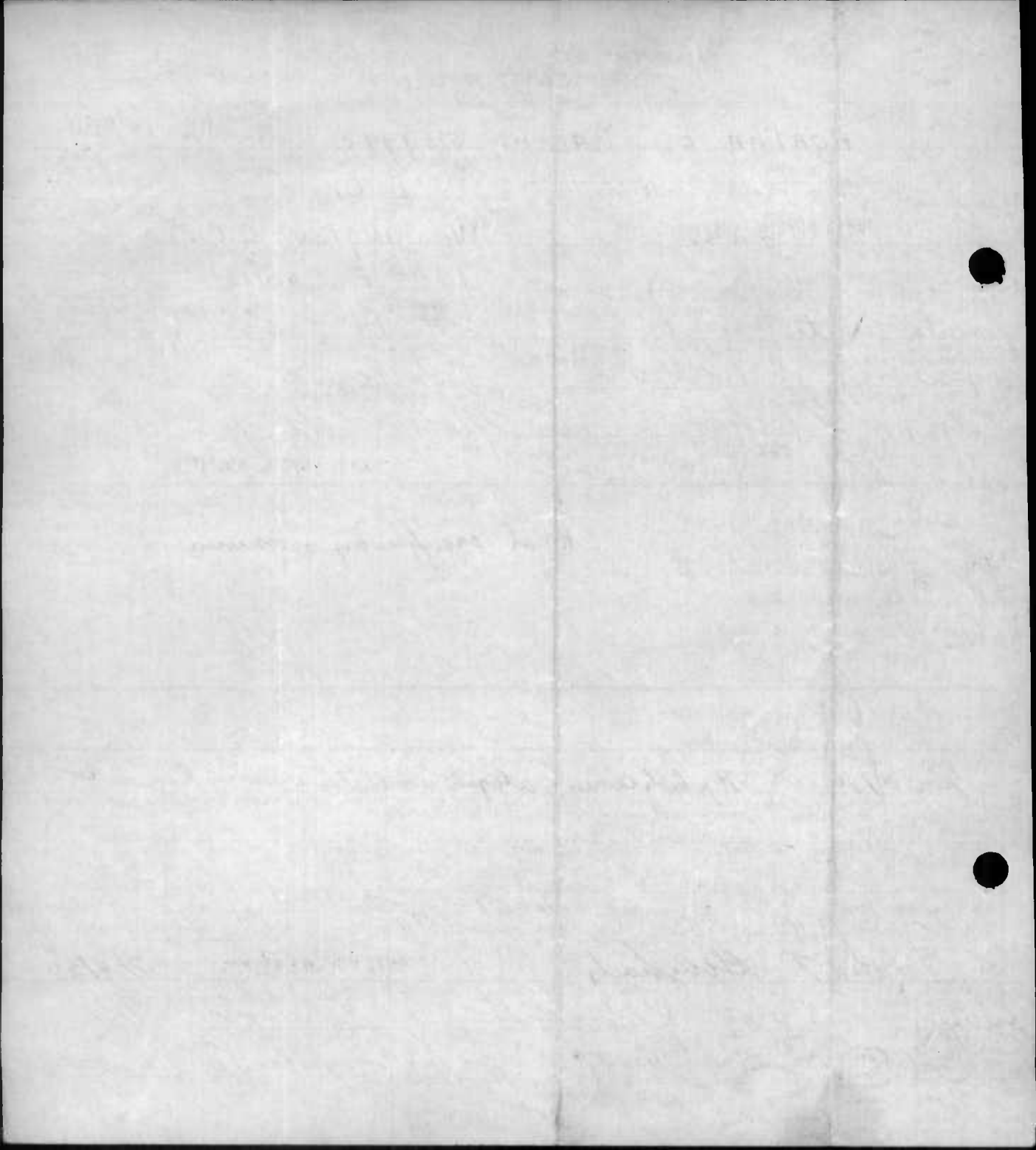
ADDRESS

W. W. Chambers, Inc.

VS 150

131a

MEDICAL CERTIFICATION



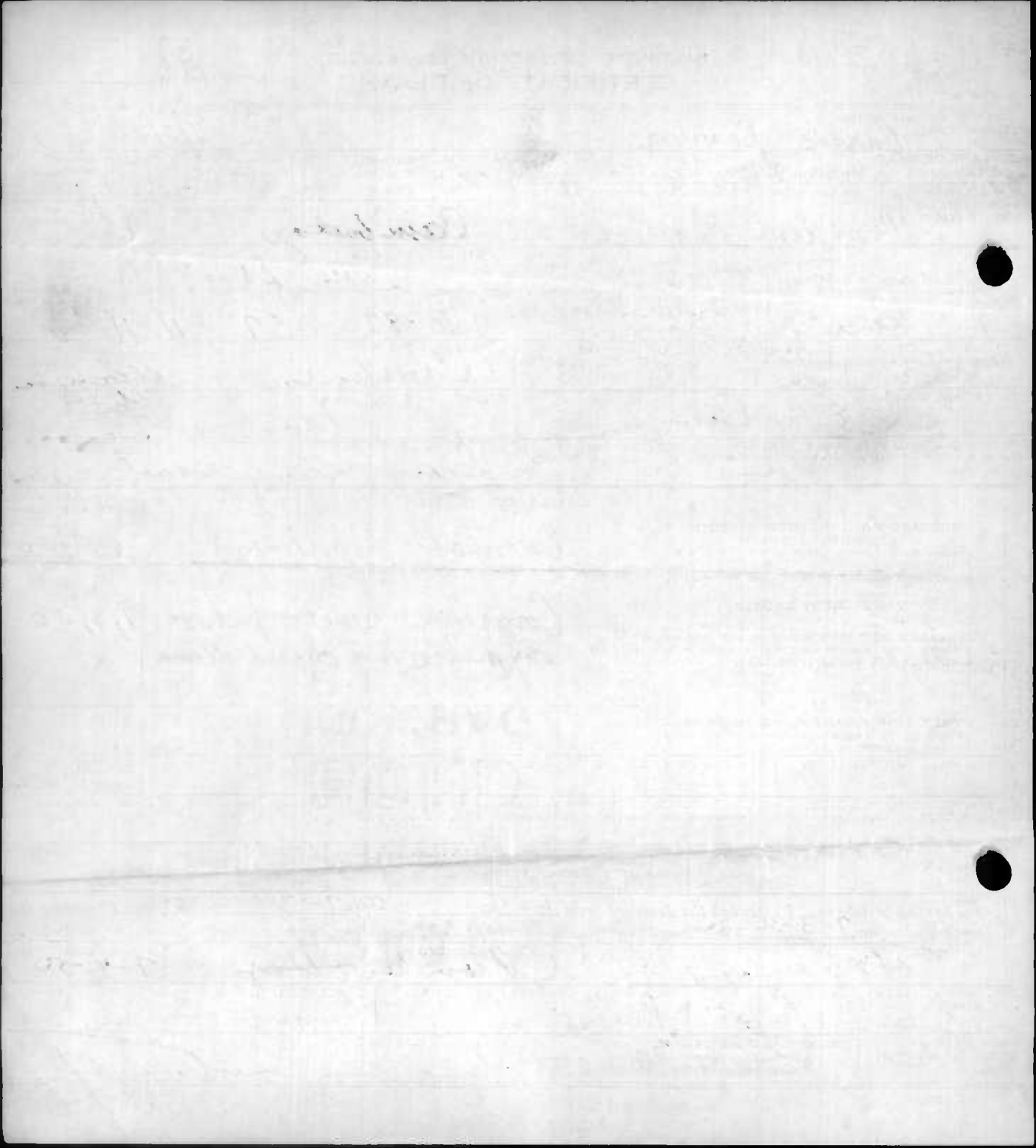
516  
50 5869BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5869  
Registered No.

BIRTH NO.

|   |                                    |   |  |
|---|------------------------------------|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Carrie Camper</i>   |                                    | 2. DATE OF DEATH<br><i>7/3/50</i>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>Provident Hospital</i>   |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Mass.</i> B. COUNTY <i>Dorchester County</i> |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>Provident Hospital</i>  |                                    | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Cambridge</i>  |  |
| 5. Length of stay in Baltimore<br><i>18</i> Yrs. <input checked="" type="checkbox"/> Mos. <input type="checkbox"/> Days |                                    | D. STREET ADDRESS (If rural, give location)<br><i>Pine Street 5913</i>  |  |
| 5. SEX<br><i>F</i>  | 6. COLOR OR RACE<br><i>Colored</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Single</i>  | 8. DATE OF BIRTH<br><i>1-23-92</i>           |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Bakery worker</i>     |                                    | 10B. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (In years last birthday)<br><i>57</i> |
| 11. BIRTHPLACE (State or foreign country)<br><i>Cambridge</i>   |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  |
| 13. FATHER'S NAME<br><i>Steven E. W. Camper</i>   |                                    | 14. MOTHER'S MAIDEN NAME<br><i>Unknown</i>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><i>no</i>  |                                    | 16. SOCIAL SECURITY NO.<br><i>no</i>  |  |
| 17. INFORMANT<br><i>Lewis Henry Cambridge</i>   |                                    | ADDRESS<br><i>Cambridge</i>   |  |

|  |   |                                  |
|--|---|----------------------------------|
| 18. <i>443 X I</i>   | CAUSE OF DEATH  | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) <i>Essential hypertension</i><br>DUE TO                                     | <i>6/30/50</i>                   |
| ANTECEDENT CAUSES  | (B) <i>Congestive heart failure</i><br>DUE TO <i>Hypertensive heart disease</i> | <i>7/3/50</i>                    |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  | (C)   |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |   |                                  |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 19A. DATE OF OPERATION<br><i>no</i>  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <i>6-16</i> , 19 <i>50</i> , to <i>7-3</i> , 19 <i>50</i> ; that I last saw the deceased alive on <i>7-3-50</i> , 19 <i>50</i> , and that death occurred at <i>3:45</i> p.m., from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE<br><i>Edith M. Ford</i>   |  | M. D.<br><i>Provident Hosp</i>  |  | 23C. DATE SIGNED<br><i>7-4-50</i>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>7/6/50 Cambridge</i>   |  | 24B. DATE<br><i>7/6/50</i>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Bethel</i>                                 |  |
| 24D. LOCATION (City, town, or county) (State)<br><i>Cambridge Mass</i>   |  | 25. FUNERAL DIRECTOR<br><i>Huntington Williams, M.D.</i>  |  | ADDRESS<br><i>Lewis Henry Cambridge</i>   |  |



50 5870

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5870

Registered No.

BIRTH NO.

|   |                                  |   |   |  |   |
|---|----------------------------------|---|---|--|---|
| 1. NAME OF DECEASED<br>(Type in full)<br><i>Walter Morris Kriel</i>   |                                  |   | 2. DATE OF DEATH<br><i>7-1-50</i>   |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>MD.</i><br>B. COUNTY <i>12-07</i>  |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>3042 St. Paul St.</i>   |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore</i>  |  |   |
| C. Length of stay in Baltimore  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><i>3042 St Paul St</i>   |  |   |
| 5. SEX<br><i>Male</i>   | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Single</i>  | 8. DATE OF BIRTH<br><i>July 11, 1877</i>  |  | 9. AGE (in years last birthday)<br><i>72</i>      |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Retired owner</i>   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>MEAT PACKING</i>  | 11. BIRTHPLACE (State or foreign country)<br><i>MARYLAND</i>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>     |
| 13. FATHER'S NAME<br><i>Chas. G. Kriel</i>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><i>Hanna E. Schmalzer</i>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)   |                                  | 16. SOCIAL SECURITY NO.<br><i>-</i>   | 17. INFORMANT ADDRESS<br><i>W. Clarence E. Kriel - 3042 St Paul</i>   |  |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>420.0</i><br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                                  |   | CAUSE OF DEATH<br>(A) <i>Pulmonary edema</i><br>DUE TO <i>was at a Health Club in Gwynedd, Pa. came home in pulmonary edema at 2:30 I was in 15 min later</i><br>(B) <i>Arteriosclerotic Heart Disease</i><br>DUE TO<br>(C) |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>1 hour</i> |
| 19A. DATE OF OPERATION<br><i>0</i>  |                                  | 19B. MAJOR FINDINGS OF OPERATION  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |                                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <i>July 1, 1950</i> to <i>July 1, 1950</i> , that I last saw the deceased alive on <i>July 1, 1950</i> and that death occurred at <i>3:30 P.m.</i> , from the causes and on the date stated above.   |                                  |   |   |  |   |
| 23A. SIGNATURE<br><i>John A. Lutscher</i>   |                                  | 23B. ADDRESS<br>M. D. <i>128. Eager St., Balto (2) MD</i>   |   | 23C. DATE SIGNED<br><i>July 1/1950</i>                                   |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Entombment</i>  |                                  | 24B. DATE<br><i>7/5/50</i>  |   | 24C. NAME OF CEMETERY OR CREMATORY<br><i>LORRAINE</i>                    |   |
| 24D. LOCATION (City, town, or county)<br><i>WINDSOR MILL RD. MD.</i>  |                                  | 25. FUNERAL DIRECTOR ADDRESS<br><i>JOHN F. DENNY, INC. 715 LIGHT ST - 30</i>                              |   |  |   |



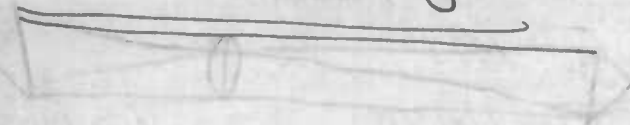
July 5<sup>th</sup> Wednesday.

Speers:

Lawyer.

Fred. Singley Jr.

NOT A MEDICAL EXAMINER'S CASE  
RS Fisher  
CHIEF OR ASST. MEDICAL EXAMINER



Left W. Singley  
P. Kay

Left W. Singley

530 50 5871

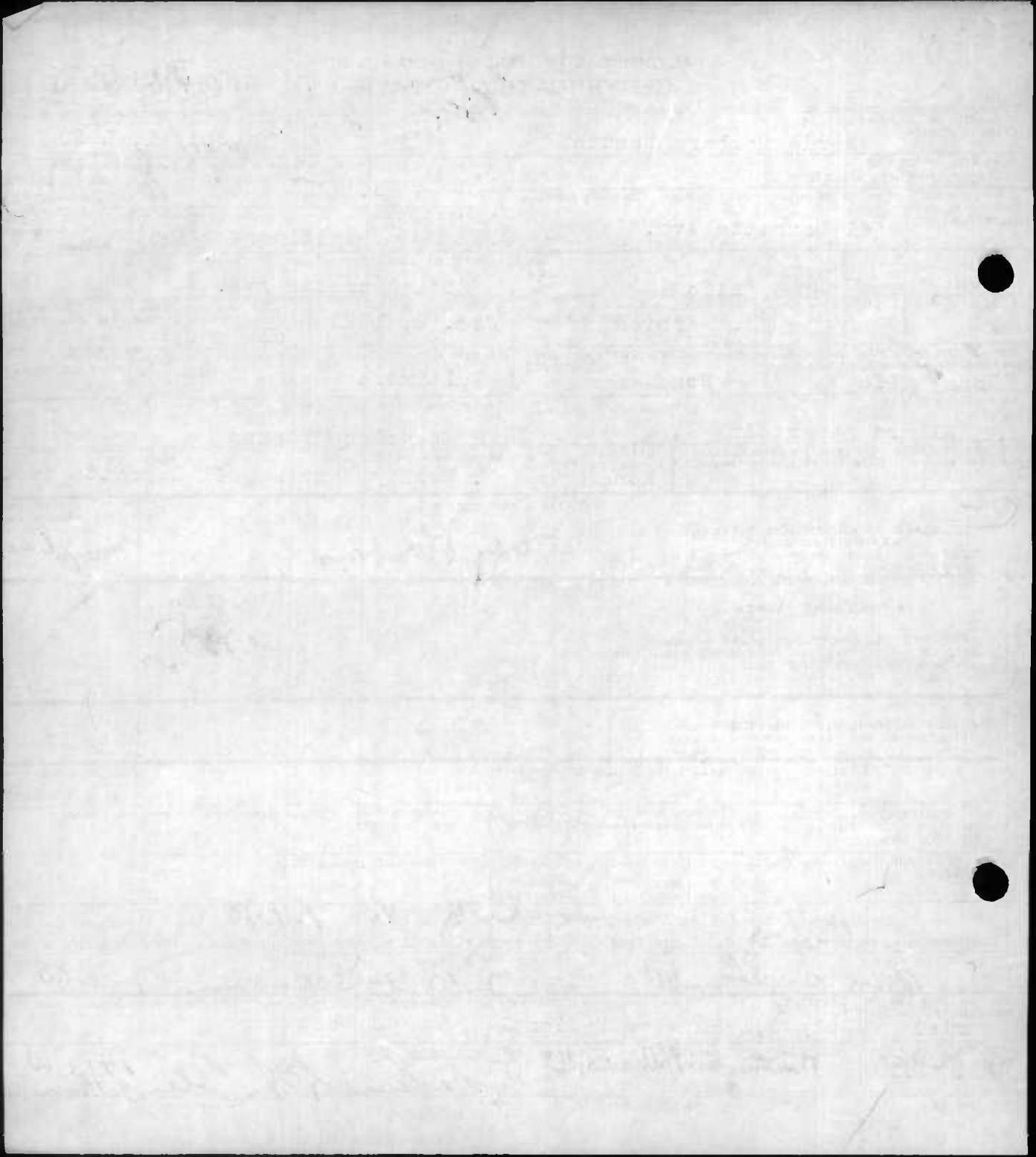
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5871

|  |                       |  |  |   |                                       |
|--|-----------------------|--|--|---|---------------------------------------|
| BIRTH NO.  |                       | 1. NAME OF DECEASED<br>(Type or Print) Marie Barbara Namuth  |  | 2. DATE OF DEATH<br>July 1, 1950  |                                       |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                       | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Md.<br>B. COUNTY |  |   |                                       |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>00 2541 Lauretta Ave.   |                       | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 20-02                    |  |   |                                       |
| D. STREET ADDRESS (If rural, give location)<br>2541 Lauretta Ave.  |                       | E. LENGTH OF STAY IN BALTIMORE<br>Life   |  |   |                                       |
| 5. SEX<br>F  | 6. COLOR OR RACE<br>W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Married   |  | 8. DATE OF BIRTH<br>Dec. 6, 1898  | 9. AGE (In years last birthday)<br>51 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>House Wife  |                       | 10B. KIND OF BUSINESS OR INDUSTRY<br>Home  |  | 11. BIRTHPLACE (State or foreign country)<br>Baltimore                              |                                       |
| 12. CITIZEN OF WHAT COUNTRY?   |                       | 13. FATHER'S NAME<br>Albert Sauerwein  |  | 14. MOTHER'S MAIDEN NAME<br>Magdalena Thomas  |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)  |                       | 16. SOCIAL SECURITY NO.<br>none  |  | 17. INFORMANT ADDRESS<br>C. Wesley Namuth 2541 Lauretta Ave.                        |                                       |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>DUE TO (A) Coronary Thrombosis<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B) DUE TO<br>(C)<br>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                       |  |  | INTERVAL BETWEEN ONSET AND DEATH<br>Approx. 2 hrs.                                  |                                       |
| 19A. DATE OF OPERATION<br>0  |                       | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                       |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  |                       | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                          |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |                                       |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   |                       | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>          |  | 21F. HOW DID INJURY OCCUR?  |                                       |
| 22. I hereby certify that I attended the deceased from March 4, 1942, to 7.1.50, 19, that I last saw the deceased alive on 6-30-50, 19, and that death occurred at 2 P.m., from the causes and on the date stated above.   |                       |  |  |   |                                       |
| 23A. SIGNATURE<br>Karl S. Lumbel   |                       | 23B. ADDRESS<br>M. D. 2703 Edmonson  |  | 23C. DATE SIGNED<br>7-3-50  |                                       |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |                       | 24B. DATE<br>July 5, 1950  |  | 24C. NAME OF CEMETERY OR CREMATORY<br>New National                                  |                                       |
| 24D. LOCATION (City, town, or county)<br>Baltimore   |                       | 24E. FUNERAL DIRECTOR<br>Frederick H. Cole   |  | 24F. ADDRESS<br>1913 W. Baltimore   |                                       |
| DATE RECEIVED BY<br>JUL 5 1950   |                       | REGISTRAR'S SIGNATURE<br>Huntington Williams, M.D.   |  | 25. FUNERAL DIRECTOR ADDRESS<br>1913 W. Baltimore                                   |                                       |

MEDICAL CERTIFICATION

94a



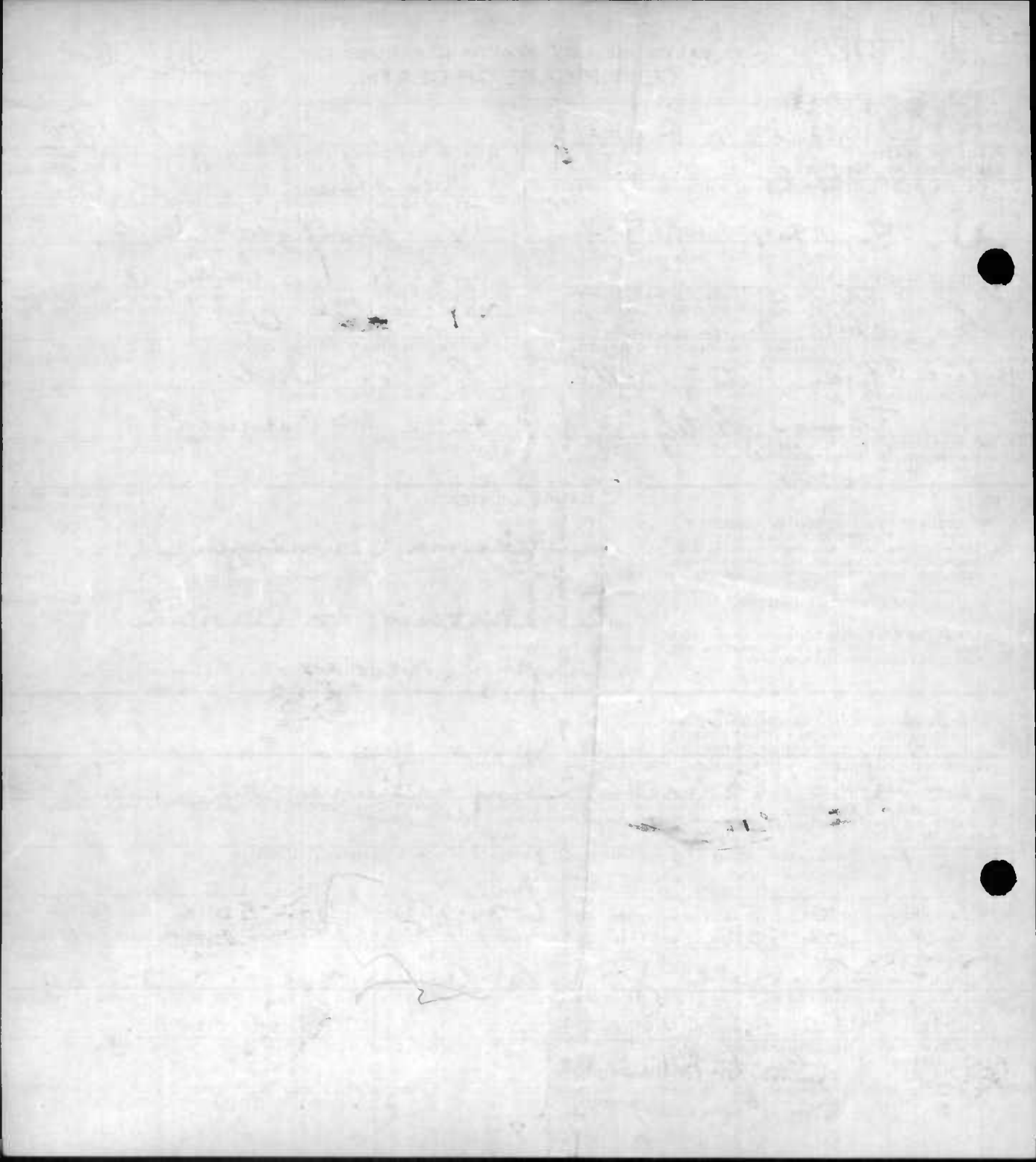
-340  
50 5872BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5872  
Registered No.

BIRTH NO.

|  |                                  |   |   |  |                                |
|--|----------------------------------|---|---|--|--------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <u>JAMES T. GATELY</u>  |                                  |   | 2. DATE OF DEATH <u>7-2-1950</u>  |  |                                |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <u>Balto. Md.</u>  |                                  |   | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <u>Maryland</u> B. COUNTY |  |                                |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><u>40 S.T. Agnes Hospital</u>   |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><u>Baltimore 20-01</u>                      |  |                                |
| C. Length of stay in Baltimore <u>Life</u>   |                                  |   | D. STREET ADDRESS (If rural, give location)<br><u>415 N. Pulaski St</u>   |  |                                |
| 5. SEX<br><u>male</u>  | 6. COLOR OR RACE<br><u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><u>married</u> | 8. DATE OF BIRTH<br><u>MAY 2 - 1886</u>   | 9. AGE (in years last birthday)<br><u>64</u> | H Under 1 Year<br>Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Police Officer</u> |                                  |   | 11. BIRTHPLACE (State or foreign country)<br><u>Balto. Md.</u>  |  |                                |
| 10B. KIND OF BUSINESS OR INDUSTRY<br><u>City of Balto.</u>   |                                  |   | 12. CITIZEN OF WHAT COUNTRY?  |  |                                |
| 13. FATHER'S NAME<br><u>Thomas Gately</u>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><u>Anne McCornick</u>   |  |                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><u>none</u>                                     |                                  |   | 16. SOCIAL SECURITY NO.<br><u>none</u>  |  |                                |
| 17. INFORMANT<br><u>Adelaide Gately</u>  |                                  |   | ADDRESS<br><u>415 N. Pulaski St.</u>  |  |                                |

|  |  |                                  |
|--|--|----------------------------------|
| 18. <u>162X</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT. | CAUSE OF DEATH<br>(A) <u>Carcinoma, Bronchogenic</u><br>DUE TO<br>(B) <u>Metastasis to Cervical</u><br>DUE TO<br>(C) <u>lymph nodes.</u> | INTERVAL BETWEEN ONSET AND DEATH |
|--|--|----------------------------------|

|   |   |  |   |   |  |
|---|---|--|---|---|--|
| 19A. DATE OF OPERATION<br><u>6-29-50</u>  |   | 19B. MAJOR FINDINGS OF OPERATION<br><u>Bronchogenic - diagnostic</u>     |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDER-<br>LYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   | 21B. PLACE OF INJURY (e. g., home or about home, farm, factory, street, office bldg., etc.)               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>INJURY   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |   |  |
| 22. I hereby certify that I attended the deceased from <u>6-29-50</u> to <u>7-2-50</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>7-2-50</u> , 19 <u>50</u> , and that death occurred at <u>4:23</u> A.m., from the causes and on the date stated above. |   |  |   |   |  |
| 23A. SIGNATURE<br><u>Arthur T. Hale Jr.</u>   |   | 23B. ADDRESS<br><u>St. Agnes Hosp.</u>                                   |   | 23C. DATE SIGNED<br><u>7-2-50</u>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 24B. DATE<br><u>July 5, 1950</u>  | 24C. NAME OF CEMETERY OR CREMATORY<br><u>New Cathedral</u>               | 24D. LOCATION (City, town, or county) (State)<br><u>Old Frederick Rd. Balto Md.</u> |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><u>UL 5-1950</u>  | REGISTRAR'S SIGNATURE<br><u>Thurston Williams, M.D.</u>   | 25. FUNERAL DIRECTOR<br><u>KRAUSE FUNERAL HOME</u>                       |   | ADDRESS<br><u>1216 S. Charles St. Balto. 30</u>                                     |  |



545  
50 5873BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5873  
Registered No.

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| BIRTH NO.   |  |  | 1. NAME OF DECEASED<br>(Type or Print) <b>PATRICK J. CONLON</b>   |  |  | 2. DATE OF DEATH <b>July 4, 1950</b>                               |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>17-03</b><br>D. STREET ADDRESS (If rural, give location) <b>406 S. Parrish Street</b> |  |  |  |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Franklin Square Hospital</b>  |  |  | 5. SEX <b>male</b>  |  |  | 6. COLOR OR RACE <b>white</b>                                      |  |  |
| C. LENGTH OF STAY IN BALTIMORE  |  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>  |  |  | 8. DATE OF BIRTH <b>Feb. 17, 1879</b>                              |  |  |
|   |  |  | 9. AGE (In years last birthday) <b>71</b>   |  |  | 10. UNDER 1 Year Months Days                                       |  |  |
|   |  |  | 11. BIRTHPLACE (State or foreign country)   |  |  | 12. CITIZEN OF WHAT COUNTRY?                                       |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Elevator operator</b> |  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Singer Sewing Machine Co.</b>   |  |  |  |  |  |
| 13. FATHER'S NAME   |  |  | 14. MOTHER'S MAIDEN NAME  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)   |  |  | 16. SOCIAL SECURITY NO.<br><b>215-10-6880</b>   |  |  | 17. INFORMANT ADDRESS<br><b>James Conlon 406 S. Parrish Street</b> |  |  |

|  |  |                                  |
|--|--|----------------------------------|
| 18. <b>E 900.0</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Subdural hemorrhage</b><br>DUE TO<br><b>Cerebral edema</b><br>DUE TO |  | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                      |  |                                  |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 19A. DATE OF OPERATION  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                      |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br><b>home</b>  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>406 S. Parrish Street</b> |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY<br><b>July 4, 1950 4.30 a.m.</b>  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?<br><b>Fell down cellar stairs</b>   |  |
| 22. I certify that I took charge of the remains described above, held an <b>autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |  |   |  |  |  |
| 23A. SIGNATURE<br><b>B. S. Fisher</b>   |  | 23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/><br>M.D. |  | 23C. DATE SIGNED<br><b>July 4, 1950</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   |  | 24B. DATE<br><b>7/7/50</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>St. Alex's Cem.</b>   |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Md.</b>   |  | 24E. FURNERAL DIRECTOR<br><b>Wm. H. Walters</b>   |  | 24F. ADDRESS<br><b>186a</b>  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 5 - 1950</b>   |  | REGISTRAR'S SIGNATURE<br><b>Wm. H. Walters</b>  |  |  |  |



STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS

Form No. 1

DEATH CERTIFICATE

NAME OF DECEASED

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

PERIOD OF ILLNESS

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5874

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Frederick W. Dalton

2. DATE OF DEATH July 3/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
Nursing Home at  
3502 Clifton Ave.4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Md.  
B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 20-07D. STREET ADDRESS (If rural, give location)  
508 Allendale St.

C. Length of stay in Baltimore

38

Yrs.  
Mos.  
Days5. SEX  
Male6. COLOR OR RACE  
W.7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
Married

8. DATE OF BIRTH

Aug. 15, 1884 65

9. AGE (in years last birthday) If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
Salesman10B. KIND OF BUSINESS OR INDUSTRY  
Sauter Graphics Office Supplies11. BIRTHPLACE (State or foreign country)  
England

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Dalton

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.  
563 01 098917. INFORMANT ADDRESS  
Emma Ursula Dalton, 508 Allendale St

18. 156-1

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Inoperable carcinoma of the

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Carcinoma of the

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

about 1 year

about 1 yr.

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 3, 1950, to July 3, 1950, that I last saw the deceased alive on July 3, 1950, and that death occurred at 4 P m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 5 - 1950

Huntington Williams, M.D.

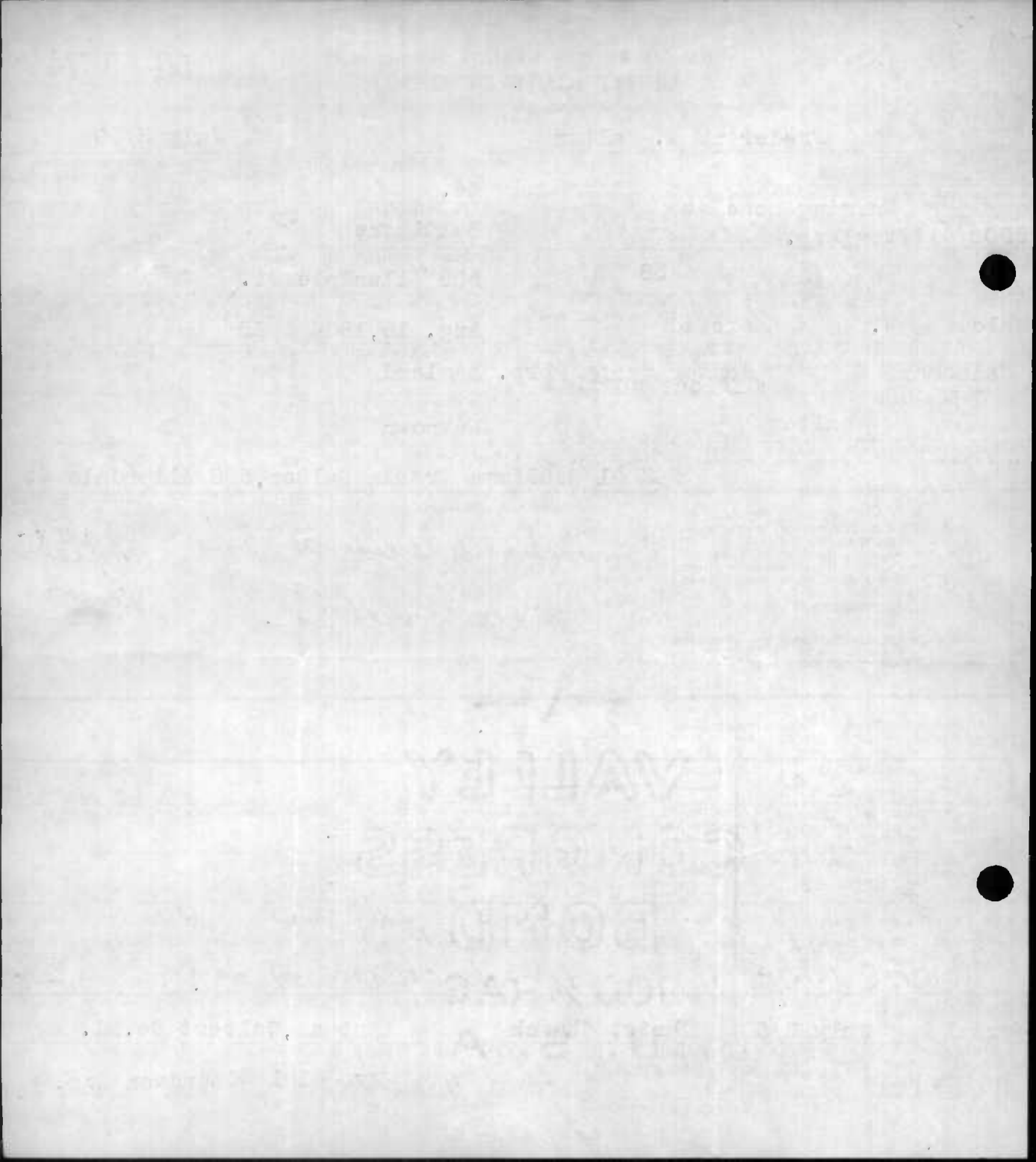
Harry D. Witzke

4101 Edmondson Ave.

VS 150

49060

46F



620

50 5875

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5875

BIRTH NO. 50-13548

1. NAME OF DECEASED  
(Type or Print)

Baby Girl HARRIS

2. DATE  
OF  
DEATH

7-3-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

BON SECOURS.

C. CITY OR TOWN

(If outside corporate limits, write RURAL, and give township)

BALTO.

25-04

D. STREET ADDRESS (If rural, give location)

824 JACK ST. - 2nd place

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

S

8. DATE OF BIRTH

7-3-50

9. AGE (In years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

-

- 30

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

None.

10B. KIND OF BUSINESS OR  
INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert L. Harris

14. MOTHER'S MAIDEN NAME

Marie S. Curran

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

No.

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Family - Same.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

ATELECTASIS

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from 7-3-1950, to 7-3-1950, that I last saw the  
deceased alive on 7-3-1950, and that death occurred at 6:35 A.M., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

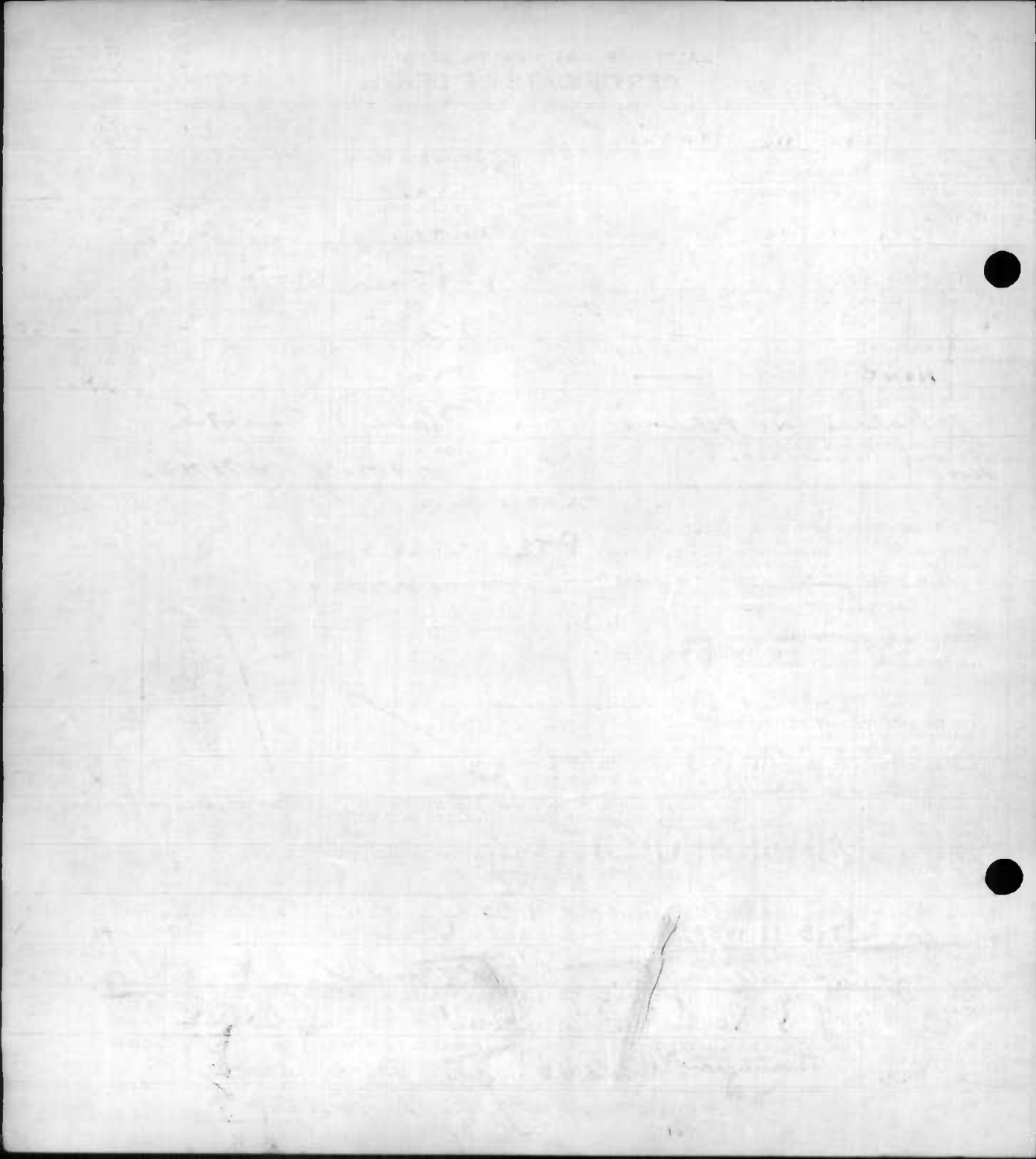
JUL 5-1950

Huntington Williams, M.D.

James L. DeLoach

130 S. Fort Ave.

161a



400  
50-5876

CERTIFICATE CORRECTED 7-20-50

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5876  
Registered No.

BIRTH NO.

|  |  |                  |  |
|--|--|------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)   |  | 2. DATE OF DEATH |  |
| MARIA E. BELL  |  | 7/2/50           |  |
| 3. PLACE OF DEATH:   |  |                  |  |
| A. Baltimore City, Maryland So. Balto. Hosp.   |  |                  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)       |  |                  |  |
| HOSPITAL OR INSTITUTION  |  |                  |  |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)               |  |                  |  |
| Curtis Bay 25-05   |  |                  |  |
| D. STREET ADDRESS (If rural, give location)  |  |                  |  |
| Hawkins Point Rd.  |  |                  |  |
| E. LENGTH OF STAY IN BALTIMORE   |  |                  |  |
| Yrs. Mos. Days   |  |                  |  |
| 5. SEX   |  |                  |  |
| F  |  |                  |  |
| 6. COLOR OR RACE   |  |                  |  |
| W  |  |                  |  |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  |  |                  |  |
| W  |  |                  |  |
| 8. DATE OF BIRTH   |  |                  |  |
| 4/8/1896 1898  |  |                  |  |
| 9. AGE (in years last birthday)  |  |                  |  |
| 54 52  |  |                  |  |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |  |                  |  |
| Housework  |  |                  |  |
| 10a. KIND OF BUSINESS OR INDUSTRY  |  |                  |  |
| Home   |  |                  |  |
| 11. BIRTHPLACE (State or foreign country)  |  |                  |  |
| Virginia   |  |                  |  |
| 12. CITIZEN OF WHAT COUNTRY?   |  |                  |  |
| 13. FATHER'S NAME  |  |                  |  |
| Unknown  |  |                  |  |
| 14. MOTHER'S MAIDEN NAME   |  |                  |  |
| Unknown  |  |                  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)        |  |                  |  |
| No   |  |                  |  |
| 16. SOCIAL SECURITY NO.  |  |                  |  |
| 17. INFORMANT ADDRESS  |  |                  |  |
| Family - Same  |  |                  |  |

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                            |  | CAUSE OF DEATH  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| (A) DUE TO   |  | A cute right ventricular cardiac plane 2 hrs.   |  |  |  |
| (B) DUE TO   |  | Bronchial Asthma  |  | years  |  |
| (C) DUE TO   |  |   |  |  |  |
| 19. DATE OF OPERATION  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?   |  |
| 0  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |
| 21A. ACCIDENT WAS UNDER- LYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME (Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED  |  | 21F. HOW DID INJURY OCCUR?   |  |
| INJURY   |  | WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK         |  |  |  |
| 22. I hereby certify that I attended the deceased from June 10, 1950, to July 2, 1950, that I last saw the deceased alive on June 30, 1950, and that death occurred at 11 P. M., from the causes and on the date stated above. |  |   |  |  |  |

|  |  |                       |  |                                    |  |
|--|--|-----------------------|--|------------------------------------|--|
| 23A. SIGNATURE                             |  | 23B. ADDRESS          |  | 23C. DATE SIGNED                   |  |
| Sidney P. Gehlert                          |  | 4700 Pennington Ave.  |  | 7/3/50                             |  |
| 24A. BURIAL, CREMA TION, REMOVAL (Specify) |  | 24B. DATE             |  | 24C. NAME OF CEMETERY OR CREMATORY |  |
| B  |  | 7/5/50                |  | Glen Haven                         |  |
| 24D. LOCATION (City, town, or county)      |  | 24E. FUNERAL DIRECTOR |  | 24F. ADDRESS                       |  |
| Glen Burnie                                |  | James L. DeCary       |  | - 130 E. Port Ave.                 |  |
| DATE RECEIVED BY LOCAL REGISTRAR           |  | REGISTRAR'S SIGNATURE |  | 25. FUNERAL DIRECTOR ADDRESS       |  |
| JUL 5-1950                                 |  | [Signature]           |  | [Signature]                        |  |
|  |  | 7208A                 |  | 112                                |  |

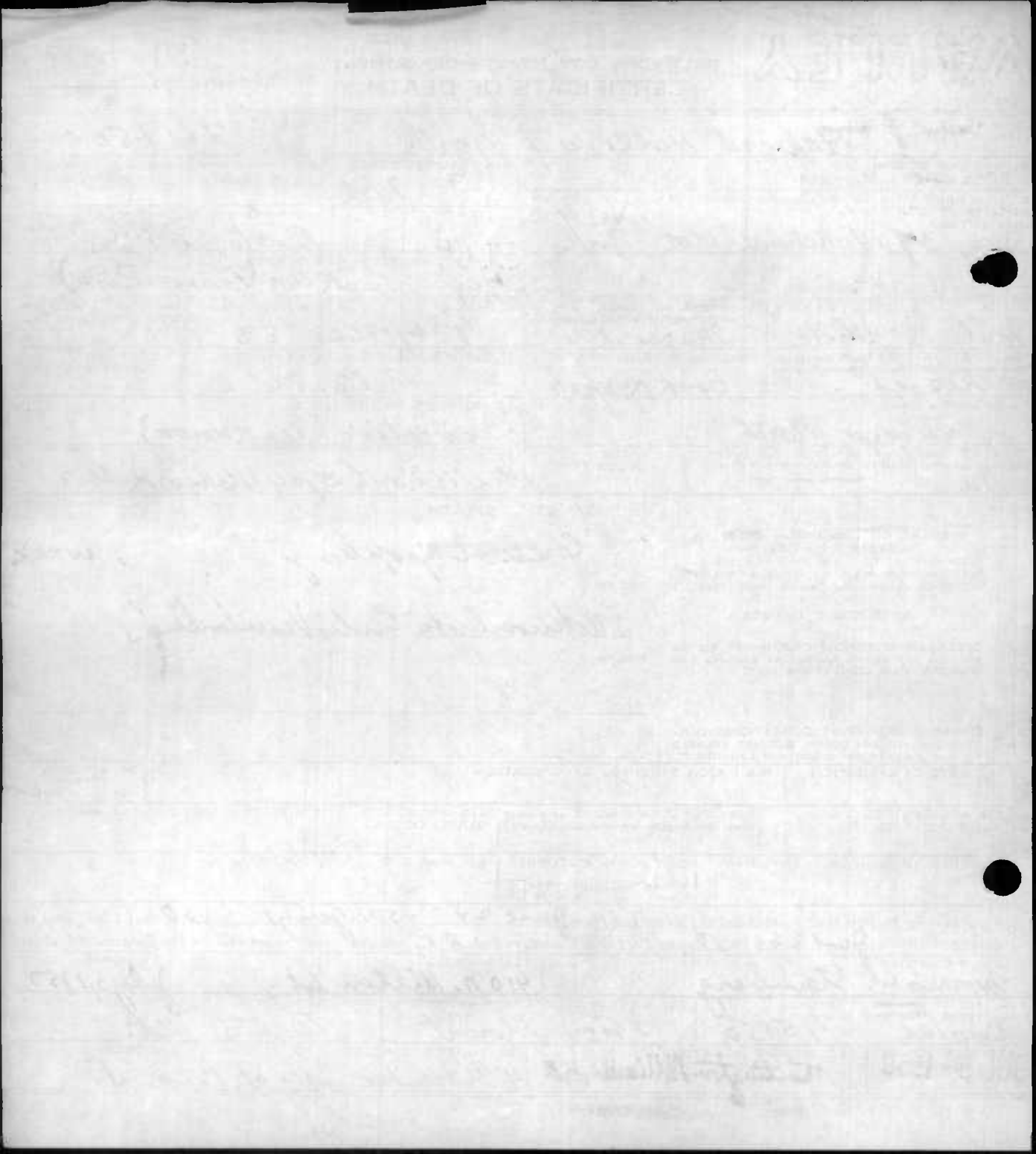


pl. 6456

cu 1185

|   |                                  |   |   |   |  |
|---|----------------------------------|---|---|---|--|
| 630<br>50 5877  |                                  | BALTIMORE CITY HEALTH DEPARTMENT<br><b>CERTIFICATE OF DEATH</b>   |   | 50 5877<br>Registered No. _____   |  |
| BIRTH NO. _____   |                                  |   |   |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Howard Holliday North</i>   |                                  |   | 2. DATE OF DEATH<br><i>7/1/50</i>   |   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Md</i> B. COUNTY _____ |   |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>3709 Mohawk Ave Forest Park</i>   |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Balto 28-01</i>                          |   |  |
| C. Length of stay in Baltimore  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><i>3709 Mohawk Ave. Forest Park</i>  |   |  |
| 5. SEX<br><i>Male</i>   | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Married</i>   | 8. DATE OF BIRTH<br><i>7/26/1866</i>  | 9. AGE (In years last birthday)<br><i>83</i>  | 10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Retired</i>   |                                  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Book Keeper</i>   |   | 11. BIRTHPLACE (State or foreign country)<br><i>Balto. Md.</i> |
| 12. CITIZEN OF WHAT COUNTRY?  |                                  |   | 13. FATHER'S NAME<br><i>James North</i>   |   |  |
| 14. MOTHER'S MAIDEN NAME<br><i>Clementine (Unknown)</i>   |                                  |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><i>No</i>                            |   |  |
| 16. SOCIAL SECURITY NO.   |                                  |   | 17. INFORMANT ADDRESS<br><i>Hellie North 3709 Mohawk Ave</i>  |   |  |
| 18. <i>422.1</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Cerebral apoplexy</i><br>CAUSE OF DEATH<br>(A) DUE TO<br>(B) <i>Arteriosclerosis Cardiovascular Disease</i><br>DUE TO<br>(C) _____ |                                  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><i>1 week</i>              |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                                  |   |   |   |  |
| 19A. DATE OF OPERATION  |                                  | 19B. MAJOR FINDINGS OF OPERATION  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <i>June 24</i> , 1950, to <i>July 1</i> , 1950, that I last saw the deceased alive on <i>June 26</i> , 1950, and that death occurred at <i>8 P. m.</i> , from the causes and on the date stated above.   |                                  |   |   |   |  |
| 23A. SIGNATURE<br><i>Morris W. Steinberg</i>  |                                  | 23B. ADDRESS<br><i>410 N. Hilton St.</i>  |   | 23C. DATE SIGNED<br><i>July 3, 1950</i>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |                                  | 24B. DATE<br><i>7/5/50</i>  |   | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Green Mount</i>                            |  |
| 24D. LOCATION (City, town, or county) (State)<br><i>Balto. Md.</i>  |                                  |   |   |   |  |
| DATE RECEIVED BY LEGAL REGISTRAR<br><i>JUL 5 1950</i>   |                                  | REGISTRAR'S SIGNATURE<br><i>Thurston Williams, M.D.</i>   |   | 25. FUNERAL DIRECTOR<br><i>Wm Cook Inc 1217 St. Paul St.</i>                        |  |
| VS 150  |                                  |   |   |   |  |

93D



460 to be OKed By Medical Examiner

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5878 Registered No. 50 5878

BIRTH NO. 50 5878

1. NAME OF DECEASED (Type or Print) **Matilda Miller 534284**

2. DATE OF DEATH **JUL 4 - 1950**

3. PLACE OF DEATH: **A. Baltimore City, Maryland**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **Md.** B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION **JOHNS HOPKINS HOSPITAL**

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Baltimore 4-01**

7. STREET ADDRESS (If rural, give location)  
**110 W. Mulberry St.**

8. DATE OF BIRTH **3-16-68**

9. AGE (In years last birthday) **82**

10. BIRTHPLACE (State or foreign country)  
**Baltimore Md**

11. CITIZEN OF WHAT COUNTRY?  
**Christian England**

12. FATHER'S NAME  
**Christian Krumm**

13. MOTHER'S MAIDEN NAME  
**Christiana Eagle**

14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

15. SOCIAL SECURITY NO.

16. INFORMANT ADDRESS  
**JOHNS HOPKINS HOSPITAL**

17. CAUSE OF DEATH  
**Hortic Aneurysm, Rupture of 8 hours**

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
**ARTERIOSCLEROSIS**

19. ANTECEDENT CAUSES  
**FRacture Left Hip**

20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT.  
**11 weeks**

21. DATE OF OPERATION **April 13, 1950**

22. MAJOR FINDINGS OF OPERATION  
**FRacture LEFT HIP**

23. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

24. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  
**STREET**

25. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  
**MULBERRY + PARK AVE**

26. TIME (Month) (Day) (Year) (Hour) **APRIL 11, 1950 6 P.m.**

27. INJURY OCCURRED  
**FELL ON CURB**

28. I hereby certify that I attended the deceased from **4-11-1950** to **7-4-1950** that I last saw the deceased alive on **7-4-1950**, and that death occurred at **4:10 A.m.**, from the causes and on the date stated above.

29. SIGNATURE **John William Hillman**

30. ADDRESS **JOHNS HOPKINS HOSPITAL**

31. DATE SIGNED **July 4, 1950**

32. BURIAL CREMATION, REMOVAL (Specify)  
**Buried**

33. DATE **3/6/50**

34. NAME OF CEMETERY OR CREMATORY  
**Green Mount**

35. LOCATION (City, town, or county) (State)  
**Baltimore Md**

36. REGISTRAR'S SIGNATURE  
**Thurston Williams, M.D.**

37. FUNERAL DIRECTOR  
**William Cook**

38. ADDRESS  
**1217 St Paul St**

This is not a Medical Examiners Case  
as the fracture did not contri-  
bute to the death.

*R. H. Fisher*

325

50 5879

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5879  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

LILLIE FRANCES ADKINS

2. DATE  
OF

DEATH July 1, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 6701 Roberts Ave.

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE MarylandC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 26-06D. STREET ADDRESS (If rural, give location)  
6701 Roberts Ave.

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Widowed

8. DATE OF BIRTH

June 15, 1884

9. AGE (In years  
last birthday)

66

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

At home

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Platz Price

14. MOTHER'S MAIDEN NAME

Don't know

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, in or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

--

17. INFORMANT

ADDRESS

Mrs. Bessie Baskette 6701 Roberts Ave.

18. 422.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Chronic myocardial degener-  
eration  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Arteriosclerotic cardio-vascular  
disease  
DUE TO  
(C) Arteriosclerosis, generalizedII  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK22. I hereby certify that I attended the deceased from 4-22, 1946 to 7-1, 1950, that I last saw the  
deceased alive on 7-1, 1950, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

John J. Gould

M. D.

23B. ADDRESS

1471 East Ave

23C. DATE SIGNED

7-3-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/5/50

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn

24D. LOCATION (City, town, or county) (State)

Colgate, Md.

DATE RECEIVED BY  
LOG REG

JUL 5-1950

REGISTRAR'S SIGNATURE

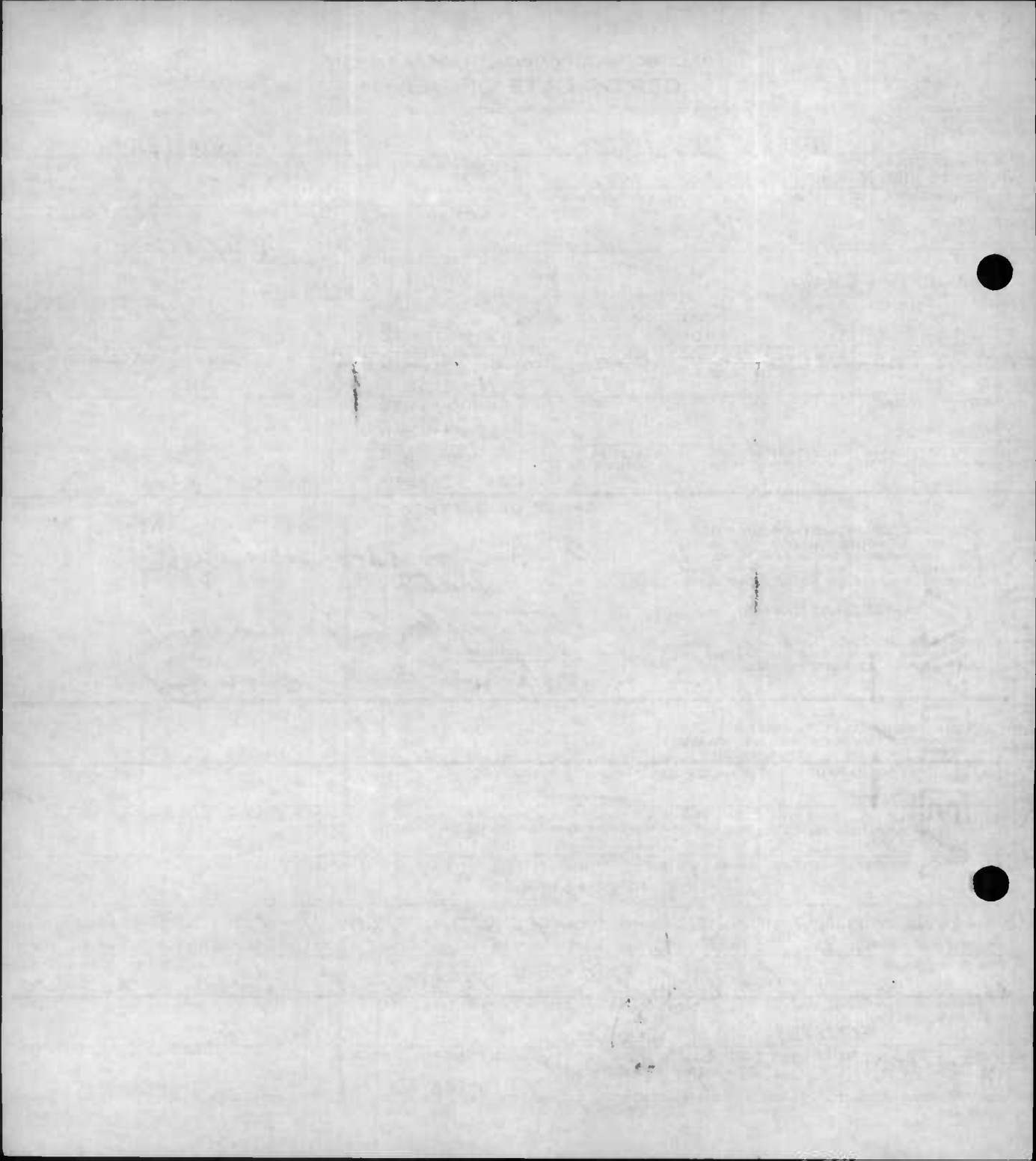
Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Ullrich Funeral Home 2008 Orleans St.





255  
50 5880BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5880

BIRTH NO.

|  |                              |   |   |  |   |
|--|------------------------------|---|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>WILLIAM RAYMOND BACKMAN</b>  |                              |   | 2. DATE OF DEATH<br><b>July 2, 1950</b>   |  |   |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>   |                              |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> |  |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>US Marine Hospital</b><br><b>Wyman Pk. Drive &amp; 31st St.</b> |                              |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore (Essex)</b>                                |  |   |
| C. Length of stay in Baltimore <b>?</b> Yrs. Mos. Days   |                              |   | D. STREET ADDRESS (If rural, give location)<br><b>Box 322 Middleboro Rd. 5300</b>   |  |   |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b> | 8. DATE OF BIRTH<br><b>12/30/08</b>   | 9. AGE (In years last birthday)<br><b>41</b> | H Under 1 Year Months: Days: H Under 24 Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Truck driver</b>   |                              | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>U. S.</b>                 | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>          |
| 13. FATHER'S NAME<br><b>George Backman</b>   |                              |   | 14. MOTHER'S MAIDEN NAME<br><b>widow states name Jessie Roesell should be Rosler</b>  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes WW 2</b>                                |                              | 16. SOCIAL SECURITY NO.<br><b>214-24-3913</b>                     | 17. INFORMANT ADDRESS<br><b>Records- US Marine Hospital, Balto, Md.</b>   |  |   |

|   |   |
|---|---|
| 18. <b>592X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Chronic glomerulonephritis</b><br>DUE TO<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Uremia ( clinical )</b><br>DUE TO<br><b>Pneumonia, left lung</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 yrs.</b><br><b>1 mo.</b><br><b>terminal</b> |
|---|---|

|  |   |   |
|--|---|---|
| 19A. DATE OF OPERATION<br><b>2</b>           | 19B. MAJOR FINDINGS OF OPERATION  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |

22. I hereby certify that I attended the deceased from **June 5**, 1950, to **July 2**, 1950, that I last saw the deceased alive on **July 2**, 1950, and that death occurred at **7:17P m.**, from the causes and on the date stated above.

|   |   |                                   |
|---|---|-----------------------------------|
| 23A. SIGNATURE<br><b>John L. Wilson, Medical Director</b> | 23B. ADDRESS<br><b>US Marine Hospital, Balto, Md.</b> | 23C. DATE SIGNED<br><b>7/3/50</b> |
|---|---|-----------------------------------|

|  |                            |   |   |
|--|----------------------------|---|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24B. DATE<br><b>7/6/50</b> | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Mem. Pk.</b> | 24D. LOCATION (City, town, or county) (State)<br><b>Howard Co., Md.</b> |
|--|----------------------------|---|---|

|   |   |   |                              |
|---|---|---|------------------------------|
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 5 - 1950</b> | REGISTRAR'S SIGNATURE<br><b>William J. Williams, M.D.</b> | 25. FUNERAL DIRECTOR<br><b>Wm. J. Williams &amp; Sons</b> | ADDRESS<br><b>Balto. Md.</b> |
|---|---|---|------------------------------|

CERTIFICATE OF DEATH

1-12-19

|                        |  |                          |  |                   |  |                        |  |                        |  |                        |  |
|------------------------|--|--------------------------|--|-------------------|--|------------------------|--|------------------------|--|------------------------|--|
| Name of Deceased       |  | Age                      |  | Sex               |  | Race                   |  | Date of Birth          |  | Place of Birth         |  |
| John Doe               |  | 45                       |  | Male              |  | White                  |  | 1910                   |  | New York               |  |
| Cause of Death         |  | Duration of Illness      |  | Time of Death     |  | Place of Death         |  | Date of Death          |  | Signature of Physician |  |
| Heart Disease          |  | 10 Days                  |  | 10:00 AM          |  | Home                   |  | 1-12-19                |  | [Signature]            |  |
| Occupation             |  | Education                |  | Marital Status    |  | Religion               |  | Social Security Number |  | Burial Place           |  |
| Teacher                |  | High School              |  | Married           |  | Catholic               |  | 123-45-6789            |  | Catholic Church        |  |
| Signature of Informant |  | Relationship to Deceased |  | Date of Statement |  | Signature of Registrar |  | Official Seal          |  | Remarks                |  |
| [Signature]            |  | Wife                     |  | 1-12-19           |  | [Signature]            |  | [Seal]                 |  | None                   |  |

50 5881

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5881

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)Charles J. Popp. (also  
Charles H. Popp)2. DATE  
OF  
DEATH

7-3-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Bon Secours Hospital

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

75 S. Morley St.

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

12-6-87

9. AGE (In years  
last birthday)

62

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR  
INDUSTRY

Ice Cream

(M)

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Popp

14. MOTHER'S MAIDEN NAME

Laura C. Lambright

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.  
219-03-235917. INFORMANT  
ADDRESS  
Mr. Raymond H. Popp - 4546 Mount View Rd

18.

446 X I

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Nephrosclerosis

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

## II

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 16, 1950, to July 31, 1950, that I last saw the  
deceased alive on July 3, 1950, and that death occurred at 9:50 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

Bon Secours Hospital

7-4-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/7/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cem.

24D. LOCATION (City, town, or county) (State)

Balto., Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 5 - 1950

Huntington Williams, M.D.

Wm. J. Sicker &amp; Sons, Balto., Md.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PERMANENT RESIDENCE

TEMPORARY RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PERMANENT RESIDENCE

TEMPORARY RESIDENCE

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 5882**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*William W. Alvey* **ALVEY**

2. DATE OF DEATH

*July 4, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

*Md.*

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

*Baltimore*

*27-19*

D. STREET ADDRESS (If rural, give location)

*5705 Berkley Ave.*

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

*Sinai Hospital of Baltimore*

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

*male*

6. COLOR OR RACE

*white*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*married*

8. DATE OF BIRTH

*March 10, 1888*

9. AGE (In years last birthday)

*62 61*

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*cost accountant*

10B. KIND OF BUSINESS OR INDUSTRY

*Sugar Refinery*

11. BIRTHPLACE (State or foreign country)

*Maryland*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*James Carroll Alvey*

14. MOTHER'S MAIDEN NAME

*Eliza Lyon*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

*no*

16. SOCIAL SECURITY NO.  
*212-09-5759*

17. INFORMANT

ADDRESS

*Mrs. William W. Alvey*

*5705 Berkley Ave.*

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

*pulmonary edema*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

*Rheumatic Heart Disease*

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

*Metastatic Carcinoma*

19A. DATE OF OPERATION

*June 23, 1950*

19B. MAJOR FINDINGS OF OPERATION

*Recto-Sigmoid Carcinoma*

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *June 19, 1950*, to *July 4, 1950*, that I last saw the deceased alive on *July 4, 1950*, and that death occurred at *9:50 A. m.*, from the causes and on the date stated above.

23A. SIGNATURE

*Elmer B. Bergant*

M. D.

23B. ADDRESS

*Sinai Hosp.*

23C. DATE SIGNED

*7/4/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*7/6/50*

24C. NAME OF CEMETERY OR CREMATORY

*Druid Ridge Cem.*

24D. LOCATION (City, town, or county)

*Pikesville, Md.*

(State)

DATE RECEIVED BY LOCAL REGISTRAR

*JUL 5 - 1950*

REGISTRAR'S SIGNATURE

*Huntington Williams, M.D.*

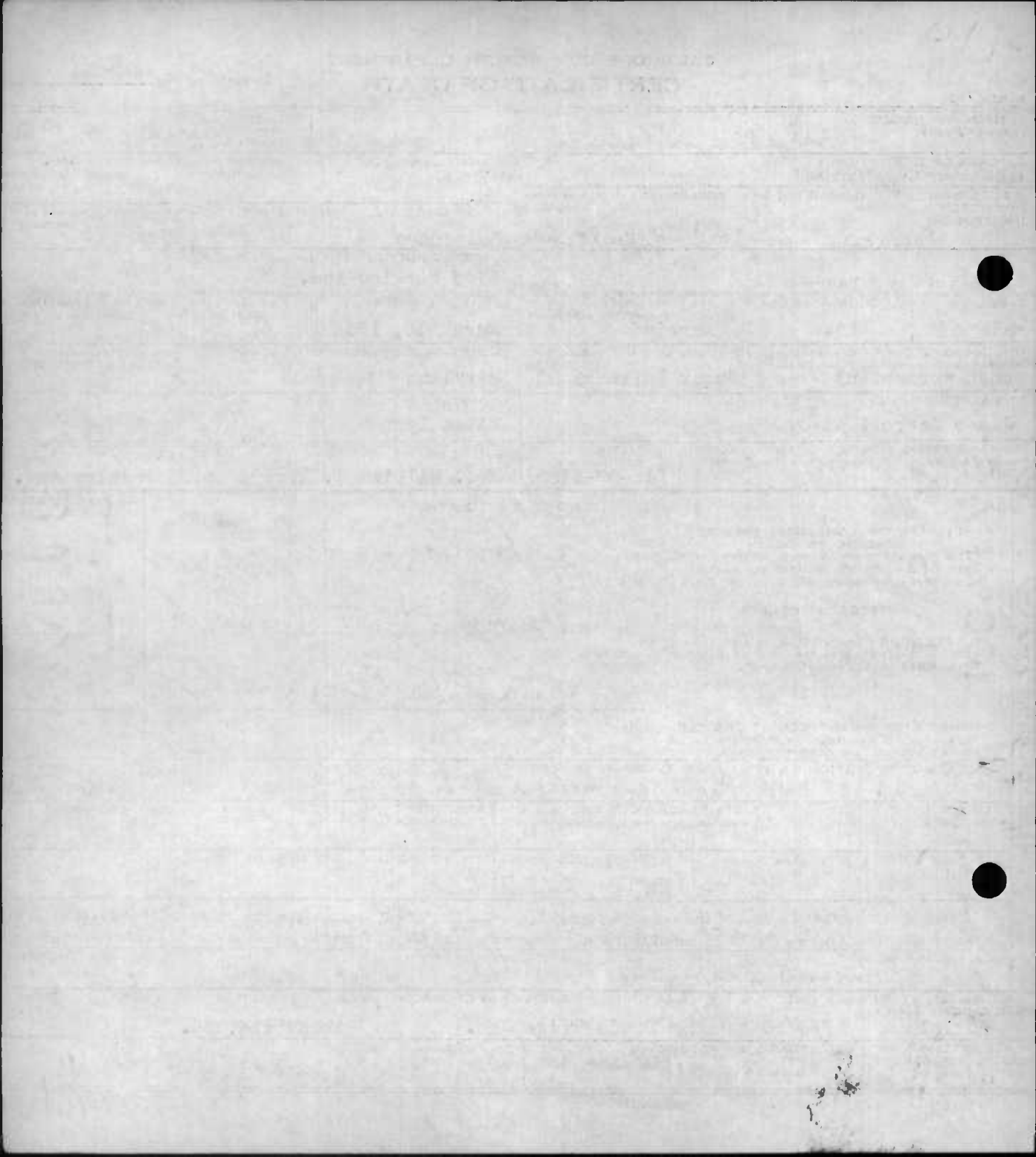
25. FUNERAL DIRECTOR

*Thos. J. Gahner & Sons - Balt.*

ADDRESS

MEDICAL CERTIFICATION





400

50 5883

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5883  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

LOUISA

HILL

2. DATE  
OF  
DEATH

7-1-50.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

3206 HAWKINS POINT RD. (CURTIS BAY)

C. Length of stay in Baltimore

10 YRS.

5. SEX

FEMALE

6. COLOR OR RACE

COLORED

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

WIDOWED

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

DOMESTIC

13. FATHER'S NAME

GENOA

PITTS

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

16. SOCIAL SECURITY NO.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

2-5-05

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE (CURTIS BAY)

D. STREET ADDRESS (If rural, give location)

3206 HAWKINS POINT ROAD

8. DATE OF BIRTH

SEPT. 13, 1873

9. AGE (in years, last birthday)

76

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

11. BIRTHPLACE (State or foreign country)

A. A. Co., Mo.

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

MARY WALKER

17. INFORMANT

ADDRESS

ESTELLE ALI-3206 HAWKINS PT. RD.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A)

Arteriosclerotic C. V. disease

DUE TO

10 1/2 HRS

## ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

## II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Jan 1, 1950, to July 1, 1950, that I last saw the deceased alive on June 30, 1950, and that death occurred at 5 PM, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

BURIAL

7-5-50

MARLEY

A. A. Co., Mo.

DATE RECEIVED BY LOCAL REGISTRY

REGISTRAR'S SIGNATURE

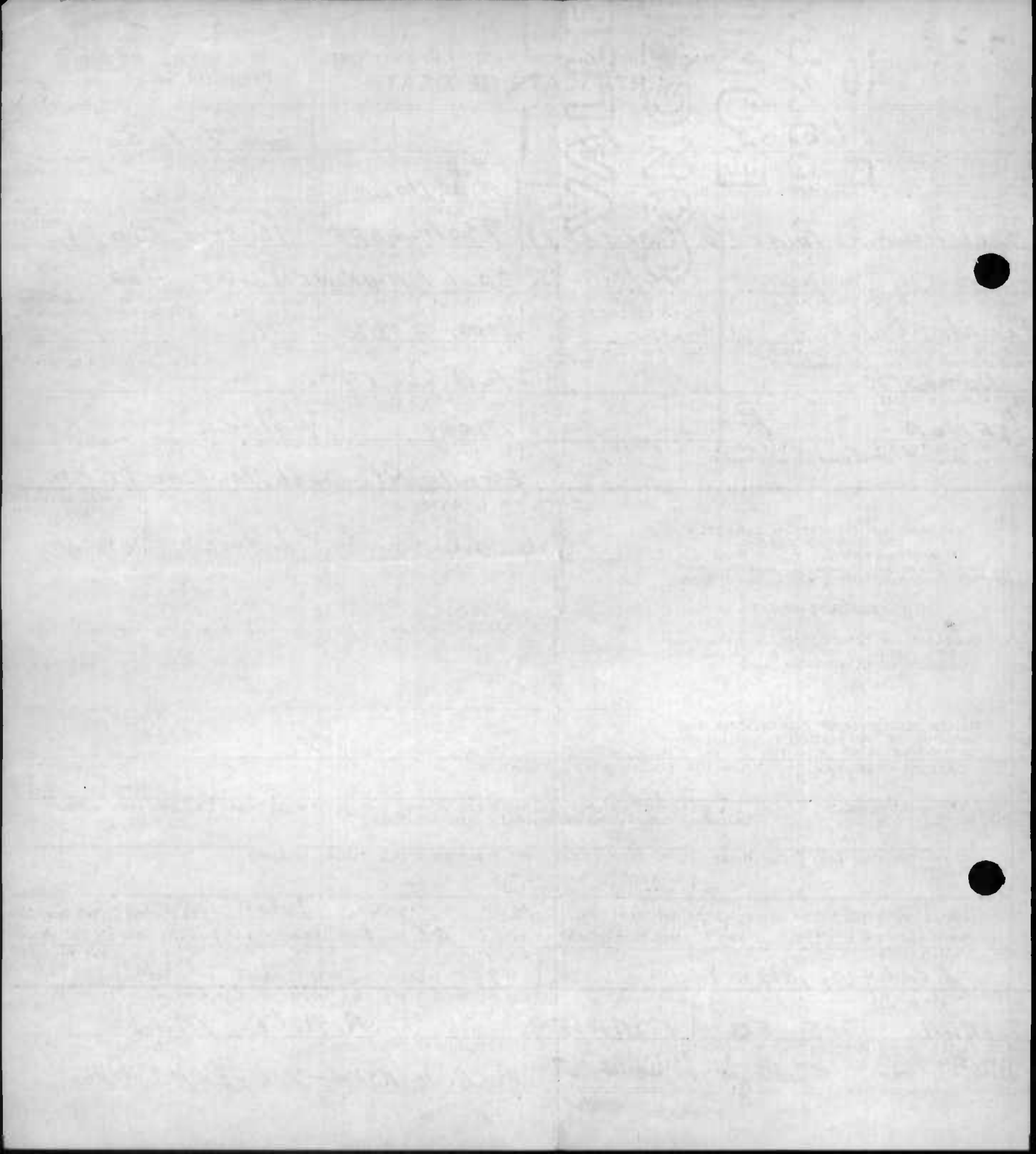
25. FUNERAL DIRECTOR

ADDRESS

JUL 5 1950

Huntington Williams, M.D.

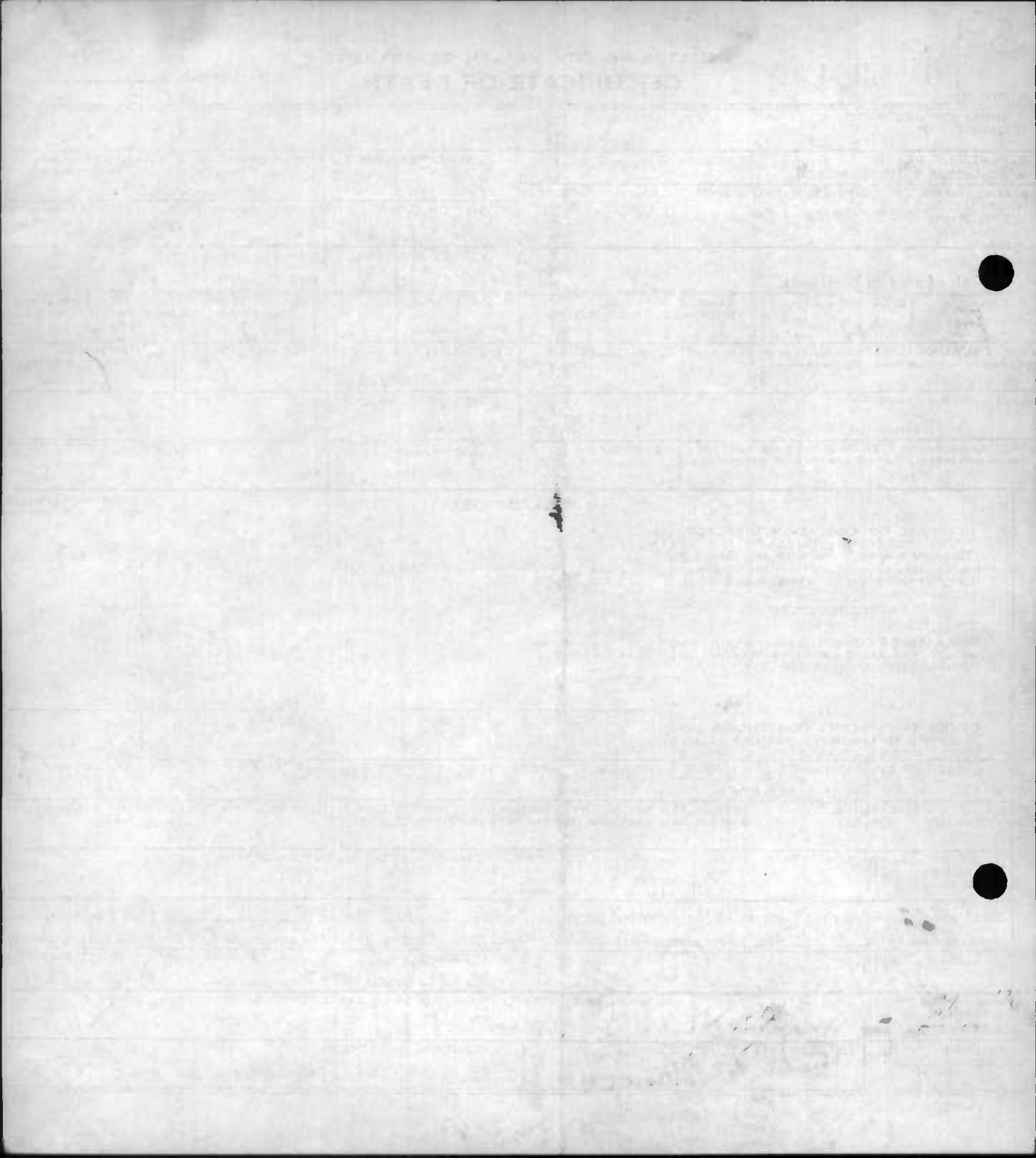
Wm. A. JACKSON - 916 PENNA. AVE.



|   |  |
|---|--|
| <div style="font-size: 2em; float: left; margin-right: 10px;">516</div> <div style="text-align: center;">             50 5884<br/> <b>BALTIMORE CITY HEALTH DEPARTMENT</b><br/> <b>CERTIFICATE OF DEATH</b> </div> <div style="text-align: right; margin-top: -20px;">             50 5884<br/>             Registered No.           </div>   |  |
| BIRTH NO.   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>STELLA HANNAH BAMBERGER</u>   |  |
| 2. DATE OF DEATH <u>JULY 3, 1950</u>  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION <u>THE UNION MEMORIAL HOSPITAL</u>  |  |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><u>BALTIMORE</u> <u>14-01</u>   |  |
| D. STREET ADDRESS (If rural, give location)<br><u>MARLBOROUGH APARTMENTS, BALTO. 17.</u>  |  |
| E. LENGTH OF STAY IN BALTIMORE <u>72</u> Yrs. <u>72</u> Days  |  |
| 5. SEX <u>F.</u> 6. COLOR OR RACE <u>W</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  |  |
| 8. DATE OF BIRTH <u>JUNE 21, 1878</u> 9. AGE (In years last birthday) <u>72</u> Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>SCHOOL TEACHER</u>  |  |
| 10B. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>   |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>  |  |
| 13. FATHER'S NAME<br><u>ANSEL BAMBERGER</u>   |  |
| 14. MOTHER'S MAIDEN NAME<br><u>HANNAH EILAU</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |  |
| 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT <u>MRS. MILTON HIRSHBERG</u> ADDRESS <u>2217 LINDEN AVE, BALTO. 17, MD.</u>   |  |
| 18. <u>170X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>DUE TO (A) <u>CARCINOMA of BREASTS, WITH DIFFUSE METASTASES</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>8 YEARS</u><br><br>ANTECEDENT CAUSES<br>(B) _____ DUE TO _____<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>(C) <u>1. HYPERTENSIVE CARDIOVASCULAR DISEASE</u><br><u>2. RIGHT HEMIPLEGIA</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>2 YRS. 1 DAY</u> |  |
| 19A. DATE OF OPERATION <u>APRIL 5, 1948</u> 19B. MAJOR FINDINGS OF OPERATION <u>1. CARCINOMA, RIGHT BREAST &amp; AXILLARY METASTASES</u> 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <u>APRIL 2, 1950</u> , to <u>JULY 3, 1950</u> , that I last saw the deceased alive on <u>JULY 3, 1950</u> , and that death occurred at <u>1:00 A.M.</u> , from the causes and on the date stated above.  |  |
| 23A. SIGNATURE <u>Alfred S. Nelson</u> M. D. 23B. ADDRESS <u>Union Memorial Hospital</u> 23C. DATE SIGNED <u>July 3, 1950</u>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u> 24B. DATE <u>July 5, 1950</u> 24C. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's Cemetery</u> 24D. LOCATION (City, town, or county) (State) <u>BALTO., MD.</u>   |  |
| DATE RECEIVED BY LOCAL REGISTRAR <u>5-1950</u> REGISTRAR'S SIGNATURE <u>Thurston Williams, M.D.</u> 25. FUNERAL DIRECTOR <u>DAVID SONDHEIMER</u> ADDRESS <u>50112 EUTAW PLACE</u>   |  |

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D350

50 5885

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5885

|  |                             |   |                                   |   |                                  |
|--|-----------------------------|---|-----------------------------------|---|----------------------------------|
| BIRTH NO.  |                             | 1. NAME OF DECEASED<br>(Type or Print) CATHERINE DUTTON   |                                   | 2. DATE OF DEATH July 3, 1950                           |                                  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                             | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE Maryland<br>B. COUNTY |                                   |   |                                  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION Provident Hospital |                             | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 15-02                         |                                   |   |                                  |
| C. Length of stay in Baltimore   |                             | D. STREET ADDRESS (If rural, give location)<br>1605 McKean Avenue   |                                   |   |                                  |
| 5. SEX<br>Female   | 6. COLOR OR RACE<br>Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>M  | 8. DATE OF BIRTH<br>Dec. 12, 1917 | 9. AGE (In years last birthday)<br>32                   | 10. Under 1 Year<br>Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work during most of working life, even if retired)<br>Waitress                                 |                             | 10B. KIND OF BUSINESS OR INDUSTRY<br>Tavern   |                                   | 11. BIRTHPLACE (State or foreign country)<br>Balto. Md. |                                  |
| 12. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |                             | 13. FATHER'S NAME<br>Giles Williams   |                                   | 14. MOTHER'S MAIDEN NAME<br>Fannie Huneter              |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br>no  |                             | 16. SOCIAL SECURITY NO.<br>?  |                                   | 17. INFORMANT ADDRESS<br>Leon Dutton 1605 McKean Ave.   |                                  |

|   |  |                                  |
|---|--|----------------------------------|
| 18. 002X<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>Pulmonary tuberculosis<br>(A) DUE TO |  | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>(B) DUE TO   |  |                                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(C) DUE TO   |  |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |                                  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 19A. DATE OF OPERATION  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                           |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>           |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that I took charge of the remains described above, held an <u>Inspection &amp; Inquiry</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <u>natural causes</u> <input checked="" type="checkbox"/> , <u>accident</u> <input type="checkbox"/> , <u>suicide</u> <input type="checkbox"/> , <u>homicide</u> <input type="checkbox"/> , <u>undetermined</u> <input type="checkbox"/> . |  |   |  |   |  |
| 23A. SIGNATURE<br>R. S. Fisher M.D.   |  | 23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> |  | 23C. DATE SIGNED<br>July 3, 1950  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 24B. DATE<br>7/5/50   |  | 24C. NAME OF CEMETERY OR CREMATORY<br>Arbutus Memorial Pk., Inc.                    |  |
| 24D. LOCATION (City, town, or county)<br>Balto. Md.   |  | 24E. FUNERAL DIRECTOR<br>Geo. G. Kelson 1303 Presstmen St.  |  | 24F. ADDRESS  |  |

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12B ✓





BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

2. DATE OF DEATH July 2, 1957

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

|   |  |
|---|--|
| B. FULL NAME OF<br>HOSPITAL OR<br>INSTITUTION | (If not in hospital or institution, give street address or location) |
|---|--|

INSTITUTION 00 1228 Mosher st

|  |     |                      |
|--|-----|----------------------|
| c. [redacted] month of stay in Baltimore | 454 | Yrs.<br>Mos.<br>Days |
|--|-----|----------------------|

|             |                       |  |
|-------------|-----------------------|--|
| 5. SEX<br>M | 6. COLOR OR RACE<br>C | 7. SINGLE, MARRIED,<br>WIDOWED, DIVORCED (Specify) |
|-------------|-----------------------|--|

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

| 17. INFORMANT   | ADDRESS         |
|-----------------|-----------------|
| Henry W. Taylor | 1228 N. 1st St. |

18. 446 X I  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

### ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

## CAUSE OF DEATH

(A) ...  
DUE TO

(B) ...  
DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION |
|------------------------|----------------------------------|
|                        |                                  |

20. AUTOPSY? ☐ YES ☐ NO

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

INJURY

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from June, 1952, to July 2, 1952, that I last saw the deceased alive on July 2, 1952, and that death occurred at 2:55 P.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C DATE SIGNED

24A: BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24c. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

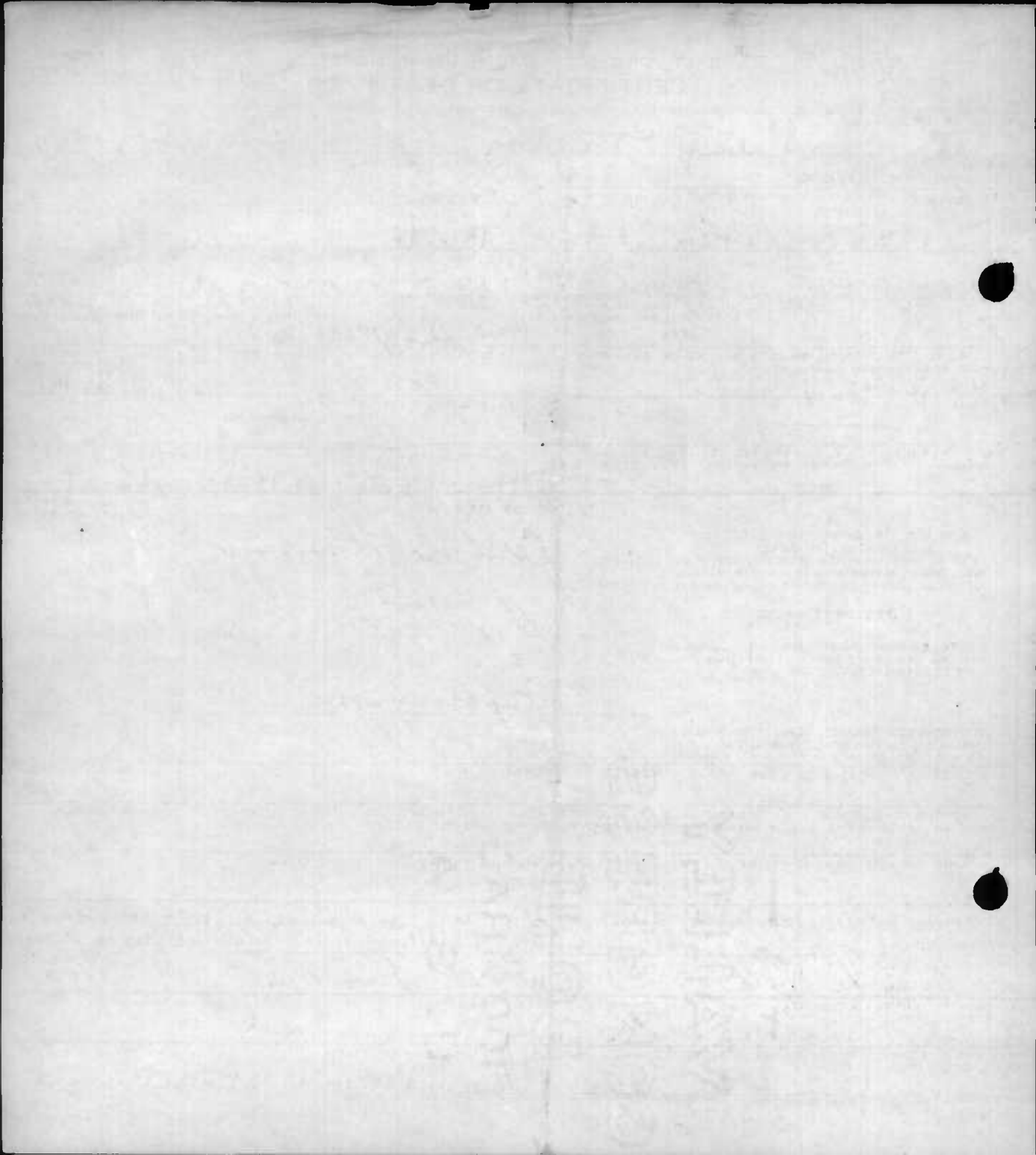
ADDRESS

JUL 5 1950

~~Confidential~~

John R. Peterson 1905 - 1968

13/a



651  
CERTIFICATE CORRECTED

7-18-50

BALTIMORE CITY HEALTH DEPARTMENT

50 5887

## CERTIFICATE OF DEATH

50 5887  
Registered No.

|  |                           |  |  |  |                                  |
|--|---------------------------|--|--|--|----------------------------------|
| BIRTH NO.  |                           |  | 2. DATE OF DEATH   |  |                                  |
| 1. NAME OF DECEASED<br>(Type or Print) HOWARD NULL CRUMBACKER  |                           |  | July 2, 1950   |  |                                  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                           |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland |  |                                  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>612 Venable Avenue  |                           |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 9-03             |  |                                  |
| C. Length of stay in Baltimore<br>Yrs. Mos. Days   |                           |  | D. STREET ADDRESS (If rural, give location)<br>612 Venable Avenue  |  |                                  |
| 5. SEX<br>Male   | 6. COLOR OR RACE<br>White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Married | 8. DATE OF BIRTH<br>Nov. 9, 1885   | 9. AGE (In years last birthday)<br>64 02 | 10. Under 1 Year<br>Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>MAINTENANCE MAN |                           |  | 11. BIRTHPLACE (State or foreign country)<br>District of Columbia  |  |                                  |
| 10B. KIND OF BUSINESS OR INDUSTRY<br>G & E Co.   |                           |  | 12. CITIZEN OF WHAT COUNTRY?   |  |                                  |
| 13. FATHER'S NAME<br>William D. Crumbacker   |                           |  | 14. MOTHER'S MAIDEN NAME<br>Ellen Ella Null  |  |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)       |                           |  | 16. SOCIAL SECURITY NO.  |  |                                  |
| 17. INFORMANT  |                           |  | ADDRESS  |  |                                  |

|  |   |                                  |
|--|---|----------------------------------|
| 18. 422.1<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>Arteriosclerotic cardiovascular disease<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | CAUSE OF DEATH<br>(A) Arteriosclerotic cardiovascular disease<br>(B)<br>(C) | INTERVAL BETWEEN ONSET AND DEATH |
|--|---|----------------------------------|

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 19A. DATE OF OPERATION  |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |  |  |  |   |  |
| 23A. SIGNATURE<br>Russell S. Fisher per Stanley H. Durlacher M.D.   |  | 23B. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/> |  | 23C. DATE SIGNED<br>July 3, 1950  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 24B. DATE<br>July 5 1950   |  | 24C. NAME OF CEMETERY OR CREMATORY<br>Greenwood                                     |  |
| 24D. LOCATION (City, town, or county)<br>Edmondson ave  |  | 24E. FUNERAL DIRECTOR<br>Harry H. Witzke   |  | 24F. ADDRESS<br>4101 Edmondson ave  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br>L 5-1950  |  | REGISTRAR'S SIGNATURE<br>Wm. H. Williams, M.D.   |  | 25. FUNERAL DIRECTOR<br>Harry H. Witzke   |  |

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CERTIFICATE OF DEATH

DEATH OF DEATH

50 5888

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5888

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)*George Geiger, Sr.*2. DATE  
OF  
DEATH*July 2/50.*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION*814 Lyndhurst St*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

*Md.*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Baltimore 16-08*

D. STREET ADDRESS (If rural, give location)

*814 Lyndhurst St.*

C. Length of stay in Baltimore

*66 yrs*Yrs.  
Mos.  
Days

5. SEX

*M.*

6. COLOR OR RACE

*W.*7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)*Widow*

8. DATE OF BIRTH

*July 27, 1861*

9. AGE (in years last birthday)

*88*If Under 1 Year  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Retired Baker*

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

*Germany*12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

*Geiger*

14. MOTHER'S MAIDEN NAME

*—*15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

*Mr. Geo. Geiger, Jr. 814 Lyndhurst*18. *442X*

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) *Ch. myocarditis & nephritis**6 mos.*

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) *Arterio-sclerosis**10 yrs.*(C) *ulcerative Colitis**2 wks.*II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from *Jan*, 1950, to *July 2*, 1950, that I last saw the deceased alive on *July 2*, 1950, and that death occurred at *5:00 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE

*Geo. C. Wells*

M. O.

23B. ADDRESS

*4100 Edmondson Ave*

23C. DATE SIGNED

*July 3, 1950*24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

*7/5/50.*

24C. NAME OF CEMETERY OR CREMATORY

*Western*

24D. LOCATION (City, town, or county) (State)

*Edmondson Ave. & Longwood St.  
Baltimore - Md.*DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Thurston Williams, Jr.*

25. FUNERAL DIRECTOR

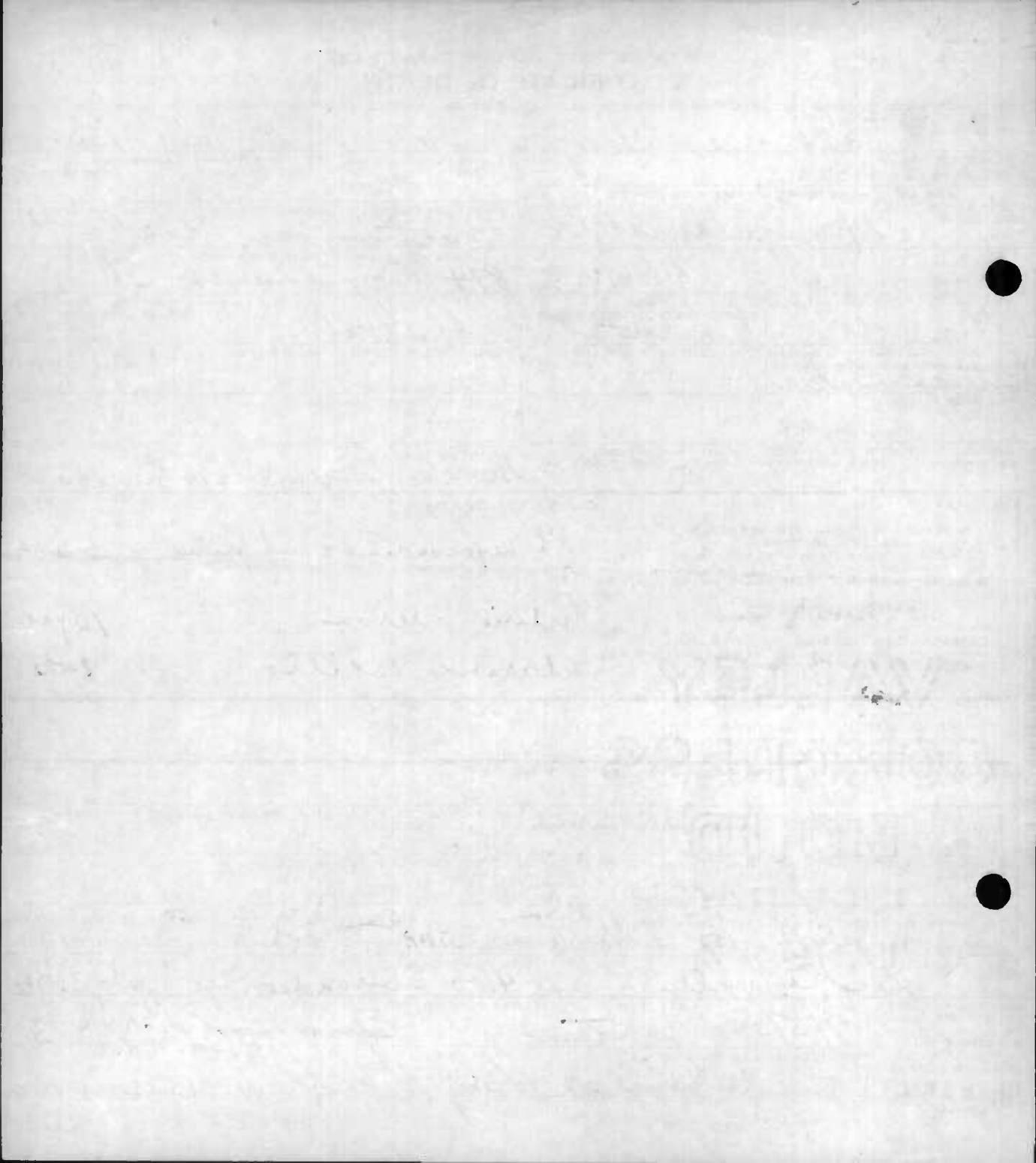
*Harry H. Gutzke, 4101 Edmondson*

ADDRESS

VS 150

*131a Ave*





220

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5889  
Registered No.

|  |                    |  |  |                                    |   |
|--|--------------------|--|--|------------------------------------|---|
| BIRTH NO. 50 5889  |                    |  | 2. DATE OF DEATH June 30, 1950   |                                    |   |
| 1. NAME OF DECEASED (Type or Print) Otis V HUGHES  |                    |  |  |                                    |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                    |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE Maryland B. COUNTY |                                    |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION Provident Hospital |                    |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 14-02                      |                                    |   |
| 5. LENGTH OF STAY IN BALTIMORE   |                    |  | D. STREET ADDRESS (If rural, give location)<br>629 Mosher St.  |                                    |   |
| 5. SEX M   | 6. COLOR OR RACE C | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single | 8. DATE OF BIRTH August 1, 1909  | 9. AGE (In years last birthday) 40 | 10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer                                |                    |  | 10B. KIND OF BUSINESS OR INDUSTRY Bowling Alley  |                                    | 11. BIRTHPLACE (State or foreign country) Baltimore Md.       |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A.  |                    |  | 13. FATHER'S NAME William Hughes   |                                    |   |
| 14. MOTHER'S MAIDEN NAME Fannie Smith  |                    |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) No.                               |                                    |   |
| 16. SOCIAL SECURITY NO.  |                    |  | 17. INFORMANT Fannie Hughes, 629 Mosher St. ADDRESS  |                                    |   |

|   |                                  |
|---|----------------------------------|
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>073X I<br>Luetic cardiovascular disease with terminal cardiac failure | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B) DUE TO<br>(C)   |                                  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                                  |

|  |  |  |
|--|--|--|
| 19A. DATE OF OPERATION   | 19B. MAJOR FINDINGS OF OPERATION   | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)         |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

|  |   |   |
|--|---|---|
| 23A. SIGNATURE R. S. Fisher                      | 23B. CHIEF MEDICAL EXAMINER.....<br>ASSISTANT MEDICAL EXAMINER.....<br>M.D. MEDICAL INVESTIGATOR..... | 23C. DATE SIGNED July 1, 1950                             |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 7-5-1950  | 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. Balto. |
| 24D. LOCATION (city, town, or county) Md.        | 25. FUNERAL DIRECTOR Mrs. Hattie P. Williams  | ADDRESS 322 N Schroeder St                                |
| DATE RECEIVED BY LOCAL REGISTRAR JUL 5 - 1950    | REGISTRAR'S SIGNATURE Huntington Williams, M.D.   |   |

# HARTFORD CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

|   |  |
|---|--|
| <p>NAME OF DECEASED _____</p> <p>AGE _____</p> <p>SEX _____</p> <p>DATE OF BIRTH _____</p> <p>PLACE OF BIRTH _____</p> <p>RESIDENCE _____</p> <p>OCCUPATION _____</p> <p>CAUSE OF DEATH _____</p> | <p>DATE OF DEATH _____</p> <p>TIME OF DEATH _____</p> <p>PLACE OF DEATH _____</p> <p>DECEASED'S SIGNATURE _____</p> <p>DECEASED'S ADDRESS _____</p> <p>DECEASED'S CITY _____</p> <p>DECEASED'S STATE _____</p> <p>DECEASED'S ZIP _____</p> |
|---|--|

|   |  |
|---|--|
| <p>NAME OF DECEASED _____</p> <p>AGE _____</p> <p>SEX _____</p> <p>DATE OF BIRTH _____</p> <p>PLACE OF BIRTH _____</p> <p>RESIDENCE _____</p> <p>OCCUPATION _____</p> <p>CAUSE OF DEATH _____</p> | <p>DATE OF DEATH _____</p> <p>TIME OF DEATH _____</p> <p>PLACE OF DEATH _____</p> <p>DECEASED'S SIGNATURE _____</p> <p>DECEASED'S ADDRESS _____</p> <p>DECEASED'S CITY _____</p> <p>DECEASED'S STATE _____</p> <p>DECEASED'S ZIP _____</p> |
|---|--|

150  
50 5890

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ADA DABNEY Dabney

2. DATE OF DEATH July 2, 1950

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) Maryland

5. FULL NAME OF (If not in hospital or institution, give street address or location) Franklin Square Hospital

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 19-02

7. STREET ADDRESS (If rural, give location) 1711 W. Lexington Street

8. Length of stay in Baltimore Yrs. Mos. Days

9. SEX Female

10. COLOR OR RACE Colored

11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married

12. DATE OF BIRTH April 16, 1884

13. AGE (In years last birthday) 66

14. Under 1 Year Months: Days

15. Under 24 Hours Hours: Min.

16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

17. KIND OF BUSINESS OR INDUSTRY

18. BIRTHPLACE (State or foreign country) Anderson, S.C.

19. CITIZEN OF WHAT COUNTRY? U.S.A.

20. FATHER'S NAME Henry Gaines

21. MOTHER'S MAIDEN NAME Nanay

22. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) No

23. SOCIAL SECURITY NO.

24. INFORMANT Dullie Dabney

25. ADDRESS 1711 W. Lexington

18. E 900.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Daughter's Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1611 W. Lexington Street

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY June 27, 1950 1:50 P.m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Slipped & fell down back steps

22. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE R S Fisher M.D.

23B. CHIEF MEDICAL EXAMINER..... ☐ ASSISTANT MEDICAL EXAMINER..... ☐ MEDICAL INVESTIGATOR..... ☐

23C. DATE SIGNED July 3, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE July 5, 1950

24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park

24D. LOCATION (City, town, or county) (State) Arbutus Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 5 - 1950

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS 322

VS 151 N-803.0 186a

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

CHIEF OF BUREAU

DATE

TIME

NAME OF DECEASED

AGE

SEX

RACE

RELATIONSHIP

EDUCATION

OCCUPATION

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

DATE OF DEATH

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PLACE OF DEATH

624  
50 5891BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Estelle Marshall</b>  |                                  | 2. DATE OF DEATH <b>7-1-1950</b>  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Md.</b><br>B. COUNTY <b>Balto.</b> |   |
| 5. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>112 N Fremont Ave</b>  |                                  | 6. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)<br><b>Balto.</b>  |   |
| 7. LENGTH OF stay in Baltimore<br>Yrs. <b>18-01</b><br>Mos. <b>18-01</b><br>Days <b>18-01</b>   |                                  | 8. STREET ADDRESS (If rural, give location)<br><b>112 N Fremont Ave</b>   |   |
| 9. SEX<br><b>Female</b>   | 10. COLOR OR RACE<br><b>Col.</b> | 11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widow</b>  | 12. DATE OF BIRTH<br><b>Feb. 22, 1893</b> |
| 13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 14. AGE (In years, last birthday)<br><b>57</b>  |   |
| 15. FATHER'S NAME<br><b>Steven Anderson</b>   |                                  | 16. MOTHER'S MAIDEN NAME<br><b>Rachel Smith</b>   |   |
| 17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>No</b>  |                                  | 18. SOCIAL SECURITY NO.<br><b>2035</b>  |   |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cerebral Hemorrhage</b>   |                                  | 20. INTERVAL BETWEEN ONSET AND DEATH  |   |
| 21. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Hypertension</b>   |                                  | 22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                     |   |
| 23. DATE OF OPERATION<br><b>0</b>   |                                  | 24. MAJOR FINDINGS OF OPERATION   |   |
| 25. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |                                  | 26. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  |   |
| 27. TIME (Month) (Day) (Year) (Hour) INJURY   |                                  | 28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |   |
| 29. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                                  | 30. HOW DID INJURY OCCUR?   |   |
| 31. I hereby certify that I attended the deceased from <b>June 30</b> , 19 <b>50</b> , to <b>July 1</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>June 30</b> , 19 <b>50</b> , and that death occurred at <b>10:30 A.M.</b> , from the causes and on the date stated above. |                                  |   |   |
| 32. SIGNATURE<br><b>James H. Carter Jr.</b>   |                                  | 33. DATE SIGNED<br><b>7/5/50</b>  |   |
| 34. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 35. DATE<br><b>July 5, 1950</b>   |   |
| 36. NAME OF CEMETERY OR CREMATORY<br><b>Balto. National</b>   |                                  | 37. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b>   |   |
| 38. DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 5 - 1950</b>   |                                  | 39. REGISTRAR'S SIGNATURE<br><b>Wm. H. Williams</b>   |   |
| 40. FUNERAL DIRECTOR<br><b>Wm. H. Williams</b>  |                                  | 41. ADDRESS<br><b>392 N. Schomberg St.</b>  |   |



7-1-1950

Estelle Marshall

Mr.

1111 Franklin Ave. Bklyn.

1111 Franklin Ave.

Brooklyn 27

in A.D.M.

1111 Franklin Ave.

1111 Franklin Ave.

1111 Franklin Ave.

1111 Franklin Ave.

1111 Franklin Ave.

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1111 Franklin Ave.

1111 Franklin Ave.

1111 Franklin Ave.

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5892  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <span style="float:right">Agnes Sewell</span>   |  |   | 2. DATE OF DEATH<br>July 4, 1950   |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <span style="float:right">Maryland</span><br>B. COUNTY _____ |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>(If not in hospital or institution, give street address or location)<br><span style="float:right">1119 Parrish St.</span> |  |   | C. CITY OR TOWN<br>(If outside corporate limits, write RURAL and give township)<br><span style="float:right">Baltimore 16-02</span>                            |  |  |
| D. STREET ADDRESS (If rural, give location)<br><span style="float:right">1119 Parrish St.</span>   |  |   | E. LENGTH OF STAY IN BALTIMORE<br><span style="float:right">2 - Yrs. Mos. Days</span>  |  |  |
| 5. SEX<br><span style="float:right">F</span>   | 6. COLOR OR RACE<br><span style="float:right">C</span> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><span style="float:right">Widowed</span> | 8. DATE OF BIRTH<br><span style="float:right">1986-10-29</span>  |  | 9. AGE (In years last birthday)<br><span style="float:right">63</span> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><span style="float:right">Housewife</span>                            |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><span style="float:right">Home</span>                  | 11. BIRTHPLACE (State or foreign country)<br><span style="float:right">Maryland</span>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><span style="float:right">USA</span>   |
| 13. FATHER'S NAME<br><span style="float:right">Edward Dotson</span>  |  |   | 14. MOTHER'S MAIDEN NAME<br><span style="float:right">Louise Dotson</span>   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)<br><span style="float:right">✓</span>   |  | 16. SOCIAL SECURITY NO.<br><span style="float:right">✓</span>                               | 17. INFORMANT<br><span style="float:right">Mary E. Brown</span>  |  |  |
|  |  |   | ADDRESS<br><span style="float:right">1119 PARRISH ST BALTO MD</span>   |  |  |

|  |  |  |                                  |
|--|--|--|----------------------------------|
| 18. <span style="float:right">4221</span><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  | CAUSE OF DEATH<br>(A) <span style="float:right">Arteriosclerotic Cardiovascular Disease</span><br>DUE TO<br>(B) _____<br>DUE TO<br>(C) _____ | INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|----------------------------------|

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 19A. DATE OF OPERATION<br><span style="float:right">July 7-1950</span>   |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that I took charge of the remains described above, held an <u>Inspection &amp; INQ.</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <u>natural causes</u> <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |  |   |  |   |  |
| 23A. SIGNATURE<br><span style="float:right">Stanley H. Dunsen M.D.</span>  |  | 23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/> |  | 23C. DATE SIGNED<br><span style="float:right">July 5, 1950</span>                         |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><span style="float:right">Burial</span>   |  | 24B. DATE<br><span style="float:right">July 7-1950</span>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><span style="float:right">Simpson Chapel Cem</span> |  |
| 24D. LOCATION (City, town, or county)<br><span style="float:right">New Market Md</span>  |  | 24E. DATE RECEIVED BY LOCAL REGISTRAR   |  | 24F. REGISTRAR'S SIGNATURE<br><span style="float:right">Huntington Williams</span>        |  |
| 24G. FUNERAL DIRECTOR<br><span style="float:right">W. E. Falconer</span>   |  | 24H. ADDRESS<br><span style="float:right">New Market Md</span>  |  |   |  |

VSL 151-1550

937 ✓



420

50 5893

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5893

Registered No.

BIRTH NO.

|   |                                  |  |   |  |   |
|---|----------------------------------|--|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Ellie Yvonne Ellis</i>  |                                  |  | 2. DATE OF DEATH <i>July 4, 1950</i>  |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>Med. Center 3</i>  |                                  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>md.</i> B. COUNTY <i>1</i> |  |   |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>JOHNS HOPKINS HOSPITAL</i>  |                                  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 26-34</i>                          |  |   |
| 6. Length of stay in Baltimore<br>Yrs. Mos. Days  |                                  |  | D. STREET ADDRESS (If rural, give location)<br><i>4843 Wright Ave</i>   |  |   |
| 5. SEX<br><i>Female</i>   | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Single</i> | 8. DATE OF BIRTH<br><i>11-20-10</i>   |  | 9. AGE (In years last birthday) <i>39</i>     |
| 10A. USUAL OCCUPATION (Give kind of occupation during most of working life, even if retired)<br><i>Bookbinder</i> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Commercial</i>           | 11. BIRTHPLACE (State or foreign country)<br><i>Tennessee</i>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i> |
| 13. FATHER'S NAME<br><i>James F. Ellis</i>  |                                  |  | 14. MOTHER'S MAIDEN NAME<br><i>Pearl Pannel</i>   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)<br><i>No</i>                   |                                  | 16. SOCIAL SECURITY NO.  | 17. INFORMANT ADDRESS<br><i>JOHNS HOPKINS HOSPITAL</i>  |  |   |

|  |  |  |
|--|--|--|
| 18. <i>416 X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (A) <i>Cerebral embolus, left</i><br>DUE TO<br>(B) <i>Rheumatic Heart Disease</i><br>DUE TO <i>fever inactive</i><br>(C) <i>over</i> | INTERVAL BETWEEN ONSET AND DEATH<br><i>23 days</i><br><i>10-15y</i><br><i>Jo</i> |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |  |

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 19A. DATE OF OPERATION <i>0</i>  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <i>6-12-</i> , 19 <i>50</i> , <i>7-4-</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>7-4-</i> , 19 <i>50</i> and that death occurred at <i>2:35 P.M.</i> , from the causes and on the date stated above. |  |   |  |  |  |
| 23A. SIGNATURE<br><i>Joseph Stokes III</i>   |  | 23B. ADDRESS<br><i>JOHNS HOPKINS HOSPITAL</i>   |  | 23C. DATE SIGNED<br><i>7-4-50</i>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  | 24B. DATE<br><i>7/7/50</i>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Parkwood</i>                    |  |
| 24D. LOCATION (City, town, or county)<br><i>Taylor Ave</i>   |  | 24E. DATE RECEIVED BY LOCAL REGISTRAR   |  | 24F. REGISTRAR'S SIGNATURE<br><i>Wm. J. Williams, M.D.</i>               |  |
| 25. FUNERAL DIRECTOR<br><i>Mildred J. Blight</i>   |  | 25A. ADDRESS<br><i>6009 Hayford Rd.</i>   |  | 25B. DATE RECEIVED BY LOCAL REGISTRAR                                    |  |

JUL 5 1950

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Letter in document file 50-5893 - 7/13/50.

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 5894**

BIRTH NO. **50 5894**  
**60-89863**

|  |                               |  |   |  |   |
|--|-------------------------------|--|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>JOHN E DAVIS</b>   |                               |  | 2. DATE OF DEATH <b>JULY-2-1950</b>   |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>Balto</b>   |                               |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>Balto</b> |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>UNIVERSITY HOSPITAL</b>                                      |                               |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Essex</b>  |  |   |
| C. Length of stay in Baltimore   |                               |  | D. STREET ADDRESS (If rural, give location)<br><b>666 Fenway South 5300</b>   |  |   |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>Wh</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>single</b> | 8. DATE OF BIRTH<br><b>Apr. 29-1950</b>   |  | 9. AGE (In years last birthday)<br><b>2</b> Months: <b>3</b> Days: <b>3</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>none</b> |                               | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>                    | 11. BIRTHPLACE (State or foreign country)<br><b>Balto Md</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>-</b>                                    |
| 13. FATHER'S NAME<br><b>John J. Davis</b>  |                               |  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Cannon</b>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |                               | 16. SOCIAL SECURITY NO.  | 17. INFORMANT ADDRESS<br><b>John Davis (Father)</b>   |  |   |

|   |   |                                  |
|---|---|----------------------------------|
| 18. <b>E904.0</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | CAUSE OF DEATH<br>(A) <b>Multiple bruises</b><br>DUE TO <b>Subarachnoid hemorrhage</b><br>(B) <b>Spinal cord compression</b><br>DUE TO<br>(C) | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|----------------------------------|

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 19A. DATE OF OPERATION  |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                 |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Probably at home</b>   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>666 Fenway South</b> |  |
| 21D. TIME (Month) (Day) (Year) (Hour) MINUTE<br><b>? ? ? ?</b>  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?<br><b>unknown</b><br><b>Probably fell or was thrown to floor.</b>        |  |
| 22. I certify that I took charge of the remains described above, held an <b>Autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input checked="" type="checkbox"/> . |  |  |  |   |  |
| 23A. SIGNATURE<br><b>Stanley H. Durlacher</b><br>M.D.   |  | 23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/> |  | 23C. DATE SIGNED<br><b>July 2 1950</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>7-5-50</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart</b>   |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Balto., Co. Md.</b>   |  | 25. FUNERAL DIRECTOR ADDRESS<br><b>John G. Connolly 418 Eastern Ave 186a Balto 21 Md</b>   |  |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>1950</b>   |  | REGISTRAR'S SIGNATURE<br><b>Stanley H. Durlacher</b>   |  |   |  |



Probably in Spring Grove Hosp. (Mother)

R-452 5895

50 5895

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) **GEORGE ROHNIK**

2. DATE OF DEATH **7-1-50**

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **Md** B. COUNTY \_\_\_\_\_

5. FULL NAME OF (If not in hospital or institution, give street address or location)  
**1143 East Baltimore St**

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Baltimore 3-02**

7. STREET ADDRESS (If rural, give location)  
**1143 East Baltimore St**

8. Length of stay in Baltimore **62** Yrs. ~~Mo.~~ ~~Days~~

9. SEX **Male**

10. COLOR OR RACE **White**

11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **Single**

12. DATE OF BIRTH **7-10-1885**

13. AGE (In years last birthday) **64** 65

14. Under 1 Year Months: Days

15. Under 24 Hours Hours: Min.

16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Retired**

17. KIND OF BUSINESS OR INDUSTRY **Laundry Supt**

18. BIRTHPLACE (State or foreign country) **Lith**

19. CITIZEN OF WHAT COUNTRY? \_\_\_\_\_

20. FATHER'S NAME **Moses**

21. MOTHER'S MAIDEN NAME **Sarah**

22. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes, no or unknown

23. SOCIAL SECURITY NO. \_\_\_\_\_

24. INFORMANT **Morris Kervitz** ADDRESS **2406 Roslyn Ave**

25. CAUSE OF DEATH

26. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) **Coronary Thrombosis**

27. ANTECEDENT CAUSES **Chronic Myocarditis**

28. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

29. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

30. INTERVAL BETWEEN ONSET AND DEATH **1 day**  
**6 mos**

31. DATE OF OPERATION **0**

32. MAJOR FINDINGS OF OPERATION

33. AUTOPSY? YES ☐ NO ☐

34. 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

35. 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

36. 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

37. 21D. TIME (Month) (Day) (Year) (Hour) INJURY

38. 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

39. 21F. HOW DID INJURY OCCUR?

40. I hereby certify that I attended the deceased from **4/1/50** to **7/1/50**, that I last saw the deceased alive on **6/30** 19**50** and that death occurred at **11:30 p.m.** from the causes and on the date stated above.

41. SIGNATURE **Melvin L. Solomon** M. D.

42. ADDRESS **129 S. Broadway**

43. DATE SIGNED **7/5/50**

44. 24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial**

45. 24B. DATE **7-3-50**

46. 24C. NAME OF CEMETERY OR CREMATORY **Hebrew Herring Run**

47. 24D. LOCATION (City, town, or county) (State) **Baltimore, Md**

48. DATE RECEIVED BY LOCAL REGISTRAR **JUL 5 - 1950**

49. REGISTRAR'S SIGNATURE **Emmett Williams, M.D.**

50. FUNERAL DIRECTOR **Jack Lewis Inc** ADDRESS **2100 Canton Pl**

51. 2908C

52. 93D

129  
Solomon  
Island

D-436  
50

5896

DeLauder  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5896

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Thomas deLauder Jr.

2. DATE  
OF  
DEATH

July 3, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR Church Home - Hospital  
INSTITUTION Broadway & Fairmount

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 27-10

C. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

328 Winston Ave

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

Nov 3, 1938

9. AGE (In years  
last birthday)

11 1/2

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Thomas deLauder

14. MOTHER'S MAIDEN NAME

Nellie Whitaker

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

No

(If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Father

ADDRESS

18. 200.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

DUE TO

(A) Lymphosarcoma

6 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B) with metastases to  
skin, liver, Pharynx

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-7-50, 19, to 7-3-50, 19, that I last saw the  
deceased alive on 7-2-50, 19, and that death occurred at 3:00 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

Church Home - Hospital

July 3-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 5 - 1950

Huntington Williams, M.D.

John A. Moran

3000 E. Baltimore St.

VS 150

55E

CERTIFICATE OF DEATH



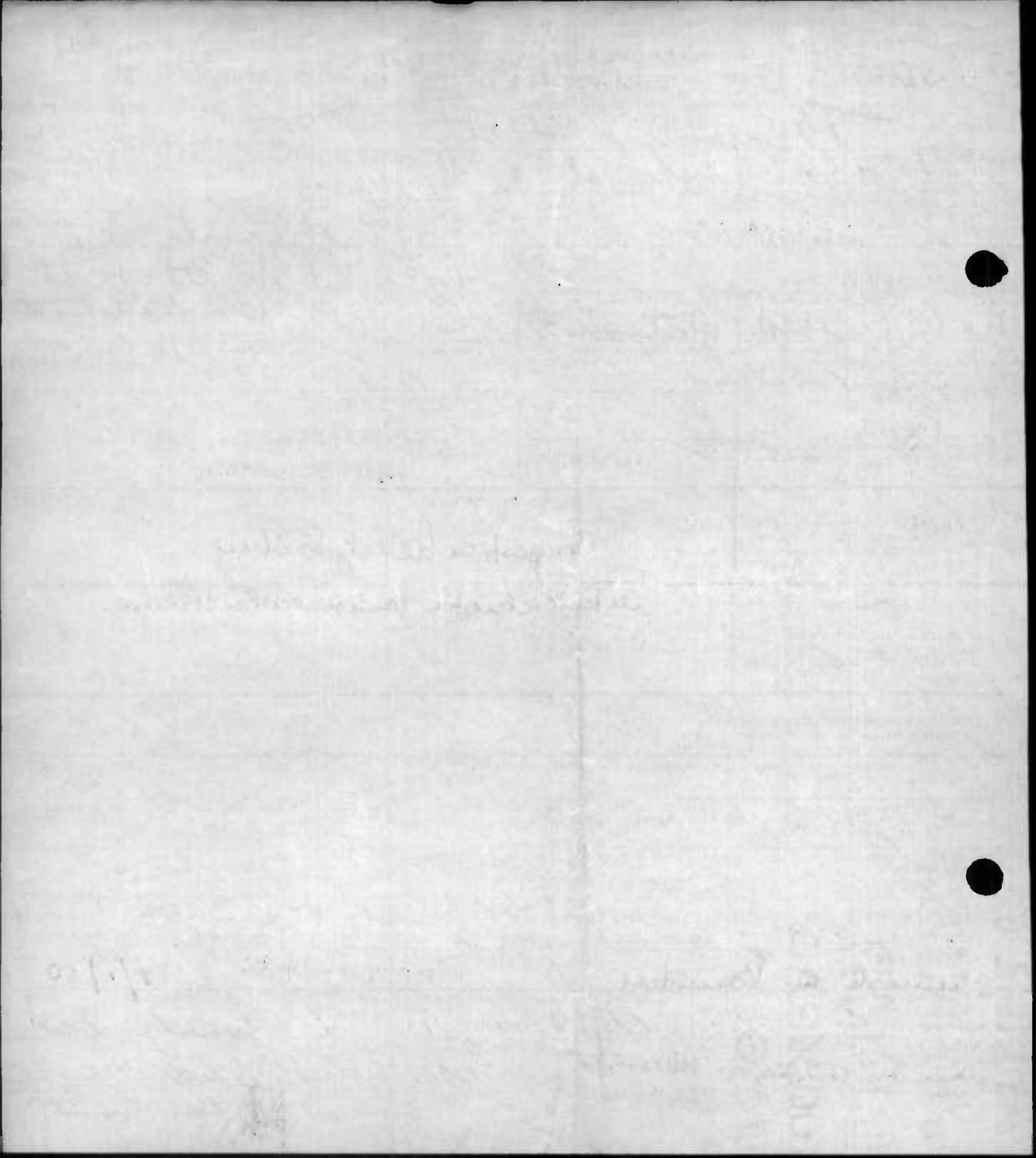
50 5897  
F-430BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5897  
Registered No.

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Benjamin Fleet</i>   |  |  | 2. DATE OF DEATH <i>June 30, 1950</i>  |  |  |
| 3. PLACE OF DEATH:<br>a. Baltimore City, Maryland <i>Med. Cal 2</i>  |  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>a. STATE <i>Md.</i> b. COUNTY |  |  |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>JOHNS HOPKINS HOSPITAL</i>   |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 5-01</i>                  |  |  |
| d. Street address (If rural, give location)<br><i>1202 St. Matthews St.</i>  |  |  | 6. DATE OF BIRTH <i>5-15-65</i>  |  |  |
| 7. SEX <i>Male</i>   |  |  | 8. AGE (In years last birthday) <i>85</i>  |  |  |
| 9. COLOR OR RACE <i>Colored</i>  |  |  | 10. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>  |  |  |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Retired Laborer</i> |  |  | 12. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13. FATHER'S NAME<br><i>unknown</i>  |  |  | 14. MOTHER'S MAIDEN NAME<br><i>unknown</i>   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><i>No</i>                     |  |  | 16. SOCIAL SECURITY NO.  |  |  |
| 17. INFORMANT<br><i>JOHNS HOPKINS HOSPITAL</i>   |  |  | ADDRESS  |  |  |

|   |  |  |
|---|--|--|
| 18. <i>477.1</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Congestive Heart Failure</i><br>DUE TO<br><i>Arteriosclerotic cardiovascular disease.</i> |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>1</i> |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B)<br>(C)  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 19A. DATE OF OPERATION <i>7</i>   |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <i>6-28-</i> , 1950 to <i>6-30-</i> , 1950 that I last saw the deceased alive on <i>6-30-</i> , 1950, and that death occurred at <i>2:30 p. m.</i> , from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE<br><i>Samuel A. Brundage</i>   |  | 23B. ADDRESS<br><i>JOHNS HOPKINS HOSPITAL</i>   |  | 23C. DATE SIGNED<br><i>7/1/50</i>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  | 24B. DATE<br><i>July 5/50</i>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Mt Calvary Cem</i>                         |  |
| 24D. LOCATION (City, town, or county) (State)<br><i>Q &amp; Q County Md</i>   |  | 24E. FUNERAL DIRECTOR<br><i>Mrs Robert G. Elbert, Jr</i>  |  | ADDRESS<br><i>1129 N. Caroline St</i>   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>5-1950</i>   |  | REGISTRAR'S SIGNATURE<br><i>Thurston Williams, M.D.</i>   |  | VS 150  |  |





50 5898

50 5898

R-512 JL-138302

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

|  |                                  |  |   |  |   |
|--|----------------------------------|--|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>John William Rimbach</b>   |                                  |  | 2. DATE OF DEATH<br><b>7-250</b>  |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Ma.</b><br>B. COUNTY |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>(If not in hospital or institution, give street address or location)<br><b>Baltimore City Hospitals<br/>4940 Eastern Ave.</b> |                                  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>                          |  |   |
| C. Length of stay in Baltimore <b>Life</b>   |                                  |  | D. STREET ADDRESS (If rural, give location)<br><b>420 N. Maderia - 31</b>   |  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Single</b> | 8. DATE OF BIRTH<br><b>Jan. 10, 1910</b>  | 9. AGE (in years last birthday)<br><b>40</b> | 10. Under 1 Year<br>Months: Days<br>11. Under 24 Hours<br>Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Mathews Mader</b>  |                                  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>International Bedding</b>   |  |   |
| 13. FATHER'S NAME<br><b>George Rimbach</b>   |                                  |  | 12. CITIZEN OF WHAT COUNTRY?  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |                                  |  | 16. SOCIAL SECURITY NO.   |  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Ma.</b>  |                                  |  | 12. MOTHER'S MAIDEN NAME<br><b>Carrie Rimbach</b>   |  |   |
| 17. INFORMANT<br><b>B. C. H. Records, 4940 Eastern Ave.</b>  |                                  |  | ADDRESS   |  |   |

|  |  |                                  |
|--|--|----------------------------------|
| 18. 002X I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Pulmonary Tuberculosis</b> |  | INTERVAL BETWEEN ONSET AND DEATH |
| (A) DUE TO   |  |                                  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B) DUE TO   |  |                                  |
| (C) DUE TO   |  |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |                                  |

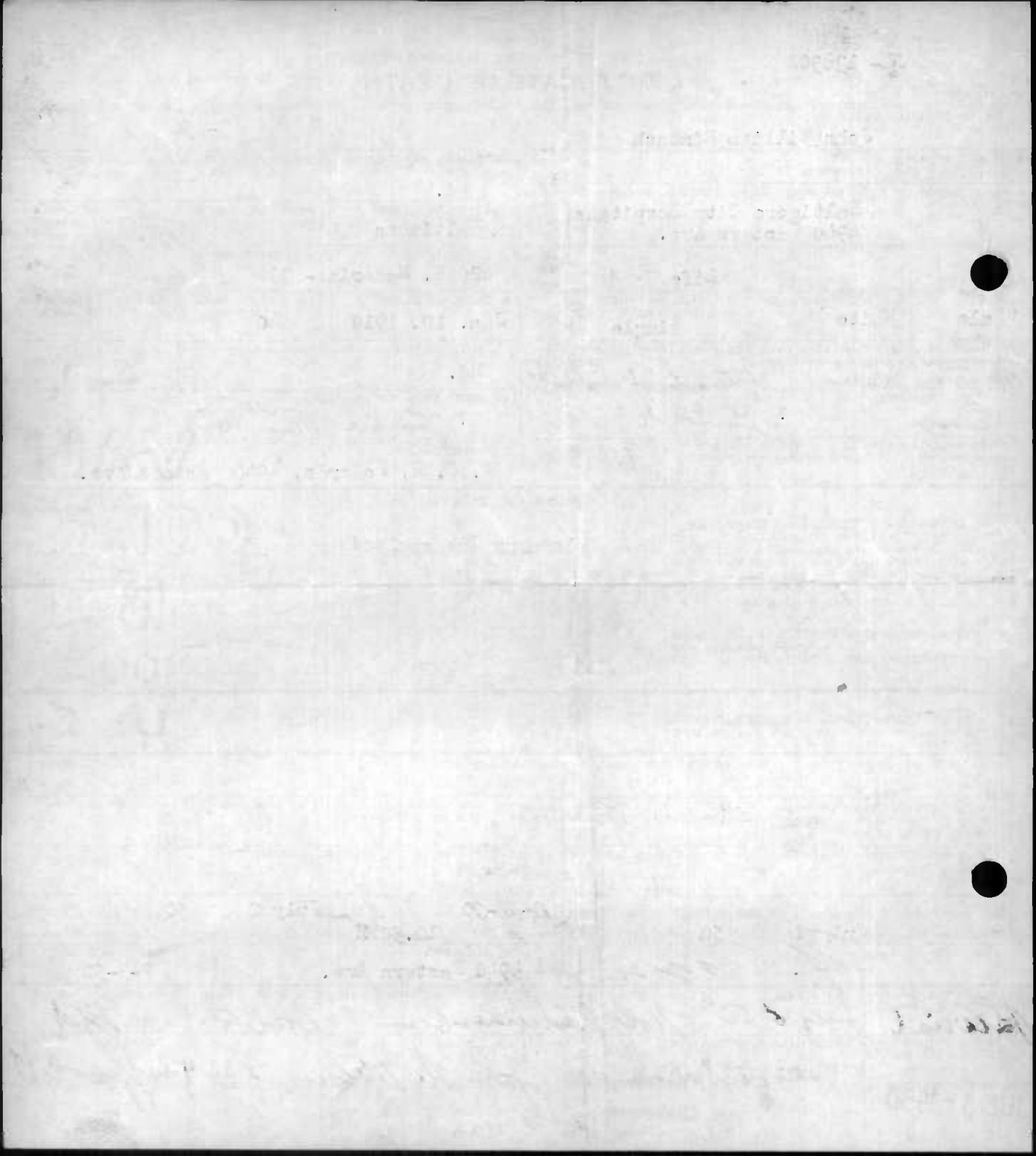
|  |   |  |  |   |  |
|--|---|--|--|---|--|
| 19A. DATE OF OPERATION<br><b>0</b>   |   | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   | 21E. INJURY OCCURRED<br>WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK | 21F. HOW DID INJURY OCCUR?   |  |   |  |
| 22. I hereby certify that I attended the deceased from <b>5-23-50</b> , 19 <b>50</b> , to <b>July 2</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>July 2</b> , 19 <b>50</b> , and that death occurred at <b>10.50 PM</b> from the causes and on the date stated above. |   |  |  |   |  |
| 23A. SIGNATURE<br><b>M. Vogen</b>  |   | 23B. ADDRESS<br><b>4940 Eastern Ave.</b>                                 |  | 23C. DATE SIGNED<br><b>7-3-50</b>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  | 24B. DATE<br><b>July 6-50</b>   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cem</b>           | 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b> |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR   | REGISTRAR'S SIGNATURE<br><b>W. H. Williams, M.D.</b>  | 25. FUNERAL DIRECTOR<br><b>John H. Miller</b>                            |  | ADDRESS<br><b>1334 Jefferson St</b>   |  |

JUL 5 1950

69033

1318

MEDICAL CERTIFICATION



B-635  
50 5899BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5899  
Registered No.

|   |                                  |  |  |   |                                  |
|---|----------------------------------|--|--|---|----------------------------------|
| BIRTH NO.   |                                  | 1. NAME OF DECEASED<br>(Type or Print) <i>John C. Bartenfelder</i>   |  | 2. DATE OF DEATH<br><i>7/3/50</i>   |                                  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <i>MD.</i><br>B. COUNTY <i>Baspeburg 26-34</i> |  |   |                                  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION <i>1304 Scheeler Ave</i>  |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baspeburg 26-34</i>   |  |   |                                  |
| c. Length of stay in Baltimore <i>life</i>  |                                  | D. STREET ADDRESS (If rural, give location)<br><i>1304 Scheeler Ave</i>  |  |   |                                  |
| 5. SEX<br><i>Male</i>   | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Married</i>  | 8. DATE OF BIRTH<br><i>Oct. 14<sup>th</sup> 1882</i> | 9. AGE (In years, last birthday)<br><i>67</i>                                       | 10. Under 1 Year<br>Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>retired</i>   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Restaurant owner</i>   |  | 11. BIRTHPLACE (State or foreign country)<br><i>Balto. Co. Md.</i>                  |                                  |
| 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |                                  | 13. FATHER'S NAME<br><i>August Bartenfelder</i>  |  | 14. MOTHER'S MAIDEN NAME<br><i>Katherine Link</i>                                   |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, oo or unknown)<br><i>NO</i>  |                                  | 16. SOCIAL SECURITY NO.<br><i>None</i>   |  | 17. INFORMANT<br><i>Mrs. J. C. Bartenfelder</i>                                     |                                  |
| 18. <i>420.1</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Coronary Occlusion</i>            |                                  | CAUSE OF DEATH<br>(A) <i>Coronary Occlusion</i><br>DUE TO<br>(B) <i>Atherosclerotic Cardiovascular Disease</i><br>DUE TO<br>(C)                  |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>2 days</i>                                   |                                  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                                  |  |  |   |                                  |
| 19A. DATE OF OPERATION <i>0</i>   |                                  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                                  | 21B. PLACE OF INJURY (e. g., io or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |                                  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>INJURY   |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?  |                                  |
| 22. I hereby certify that I attended the deceased from <i>June 1, 1950</i> to <i>July 3, 1950</i> , that I last saw the deceased alive on <i>July 2, 1950</i> and that death occurred at <i>12:30 p.m.</i> , from the causes and on the date stated above.  |                                  |  |  |   |                                  |
| 23A. SIGNATURE<br><i>Samuel B. Wolfe</i>  |                                  | 23B. ADDRESS<br><i>1331 North Ave</i>  |  | 23C. DATE SIGNED<br><i>7-5-50</i>   |                                  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |                                  | 24B. DATE<br><i>7/7/50</i>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Zion Luth.</i>                             |                                  |
| 24D. LOCATION (City, town, or county)<br><i>Balto. Co.</i>  |                                  | 24E. STATE<br><i>MD</i>  |  | 25. FUNERAL DIRECTOR<br><i>Lansdown Funeral Home</i>                                |                                  |
| DATE RECEIVED BY LOCAL REGISTRY<br><i>JUL 5 - 1950</i>  |                                  | REGISTRAR'S SIGNATURE<br><i>Huntington Williams, M.D.</i>  |  | ADDRESS<br><i>7401 Belair Rd</i>  |                                  |

Dr. S. Wolf

1331 E North

Mulberry 5733

B-600  
50 5900

50 5900

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Walter Chenoweth Berry

2. DATE  
OF  
DEATH

July 3, 1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

St. Joseph's Hospital

Yrs.  
Mos.  
Days

c. Length of stay in Baltimore

26 yr.

5. SEX

M.

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

July 6, 1904

9. AGE (In years,  
last birthday)

45

10. Under 1 Year  
Months Days11. Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Steelworker

10B. KIND OF BUSINESS OR  
INDUSTRY

Bethlehem Steel Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Elwood Berry

14. MOTHER'S MAIDEN NAME

Verna Chenoweth

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Helen V. Rhodes 601 N. Ellwood Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 31, 1950, to July 3, 1950, that I last saw the  
deceased alive on July 3, 1950, and that death occurred at 12:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

7/7/50

Toronto

Toronto Ohio.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 5 - 1950

Mintington Williams, M.D.

Clarence P. Hoffmann

1639 Broadway

VS 150

6903A

46 F



5000

UNITED STATES DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

|                                       |  |                                       |  |                                       |  |  |  |
|---------------------------------------|--|---------------------------------------|--|---------------------------------------|--|--|--|
| 1. Name of deceased                   |  | 2. Sex                                |  | 3. Age                                |  | 4. Date of death                       |  |
| 5. Place of death                     |  | 6. Cause of death                     |  | 7. Manner of death                    |  | 8. Signature of physician              |  |
| 9. Signature of registrar             |  | 10. Signature of medical examiner     |  | 11. Signature of coroner              |  | 12. Signature of jury                  |  |
| 13. Signature of health officer       |  | 14. Signature of local health officer |  | 15. Signature of local health officer |  | 16. Signature of local health officer  |  |
| 17. Signature of local health officer |  | 18. Signature of local health officer |  | 19. Signature of local health officer |  | 20. Signature of local health officer  |  |
| 21. Signature of local health officer |  | 22. Signature of local health officer |  | 23. Signature of local health officer |  | 24. Signature of local health officer  |  |
| 25. Signature of local health officer |  | 26. Signature of local health officer |  | 27. Signature of local health officer |  | 28. Signature of local health officer  |  |
| 29. Signature of local health officer |  | 30. Signature of local health officer |  | 31. Signature of local health officer |  | 32. Signature of local health officer  |  |
| 33. Signature of local health officer |  | 34. Signature of local health officer |  | 35. Signature of local health officer |  | 36. Signature of local health officer  |  |
| 37. Signature of local health officer |  | 38. Signature of local health officer |  | 39. Signature of local health officer |  | 40. Signature of local health officer  |  |
| 41. Signature of local health officer |  | 42. Signature of local health officer |  | 43. Signature of local health officer |  | 44. Signature of local health officer  |  |
| 45. Signature of local health officer |  | 46. Signature of local health officer |  | 47. Signature of local health officer |  | 48. Signature of local health officer  |  |
| 49. Signature of local health officer |  | 50. Signature of local health officer |  | 51. Signature of local health officer |  | 52. Signature of local health officer  |  |
| 53. Signature of local health officer |  | 54. Signature of local health officer |  | 55. Signature of local health officer |  | 56. Signature of local health officer  |  |
| 57. Signature of local health officer |  | 58. Signature of local health officer |  | 59. Signature of local health officer |  | 60. Signature of local health officer  |  |
| 61. Signature of local health officer |  | 62. Signature of local health officer |  | 63. Signature of local health officer |  | 64. Signature of local health officer  |  |
| 65. Signature of local health officer |  | 66. Signature of local health officer |  | 67. Signature of local health officer |  | 68. Signature of local health officer  |  |
| 69. Signature of local health officer |  | 70. Signature of local health officer |  | 71. Signature of local health officer |  | 72. Signature of local health officer  |  |
| 73. Signature of local health officer |  | 74. Signature of local health officer |  | 75. Signature of local health officer |  | 76. Signature of local health officer  |  |
| 77. Signature of local health officer |  | 78. Signature of local health officer |  | 79. Signature of local health officer |  | 80. Signature of local health officer  |  |
| 81. Signature of local health officer |  | 82. Signature of local health officer |  | 83. Signature of local health officer |  | 84. Signature of local health officer  |  |
| 85. Signature of local health officer |  | 86. Signature of local health officer |  | 87. Signature of local health officer |  | 88. Signature of local health officer  |  |
| 89. Signature of local health officer |  | 90. Signature of local health officer |  | 91. Signature of local health officer |  | 92. Signature of local health officer  |  |
| 93. Signature of local health officer |  | 94. Signature of local health officer |  | 95. Signature of local health officer |  | 96. Signature of local health officer  |  |
| 97. Signature of local health officer |  | 98. Signature of local health officer |  | 99. Signature of local health officer |  | 100. Signature of local health officer |  |

15

50 5901

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5901  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES STEPNEY

2. DATE  
OF  
DEATH

JULY 1, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Balto. City

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)A. STATE  
MD.

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or  
location)

37 MERCY HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

BALTIMORE

6-04

D. STREET ADDRESS (If rural, give location)

424 N. CHAPEL ST.

C. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

C

7. SINGLE MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Dec. 26, 1886

9. AGE (In years  
last birthday)

63

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

UNEMPLOYED LABORER -

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE

12. CITIZEN OF  
U.S.A. COUNTRY?

U.S.A.

13. FATHER'S NAME

JAMES STEPNEY

14. MOTHER'S MAIDEN NAME

TILLEY WATTS

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mable Thomas 822 N. Washington St

18. 154X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

CARCINOMA OF RECTUM

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B)

METASTASIS

(C)

HEART FAILURE

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

6/28/50

19B. MAJOR FINDINGS OF OPERATION

CA RECTUM - INTESTINAL DISTENTION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/27, 1950, to 7/1, 1950, that I last saw the  
deceased alive on 7/1, 1950, and that death occurred at 6:39 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Golden H. Perry

M. D.

23B. ADDRESS

Merry Hosp.

23C. DATE SIGNED

7/1/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

7/5/1950

24C. NAME OF CEMETERY OR CREMATORY

Mt Calvary Cem.

24D. LOCATION (City, town, or county)

Brooklyn A.A.Co.Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 5 1950

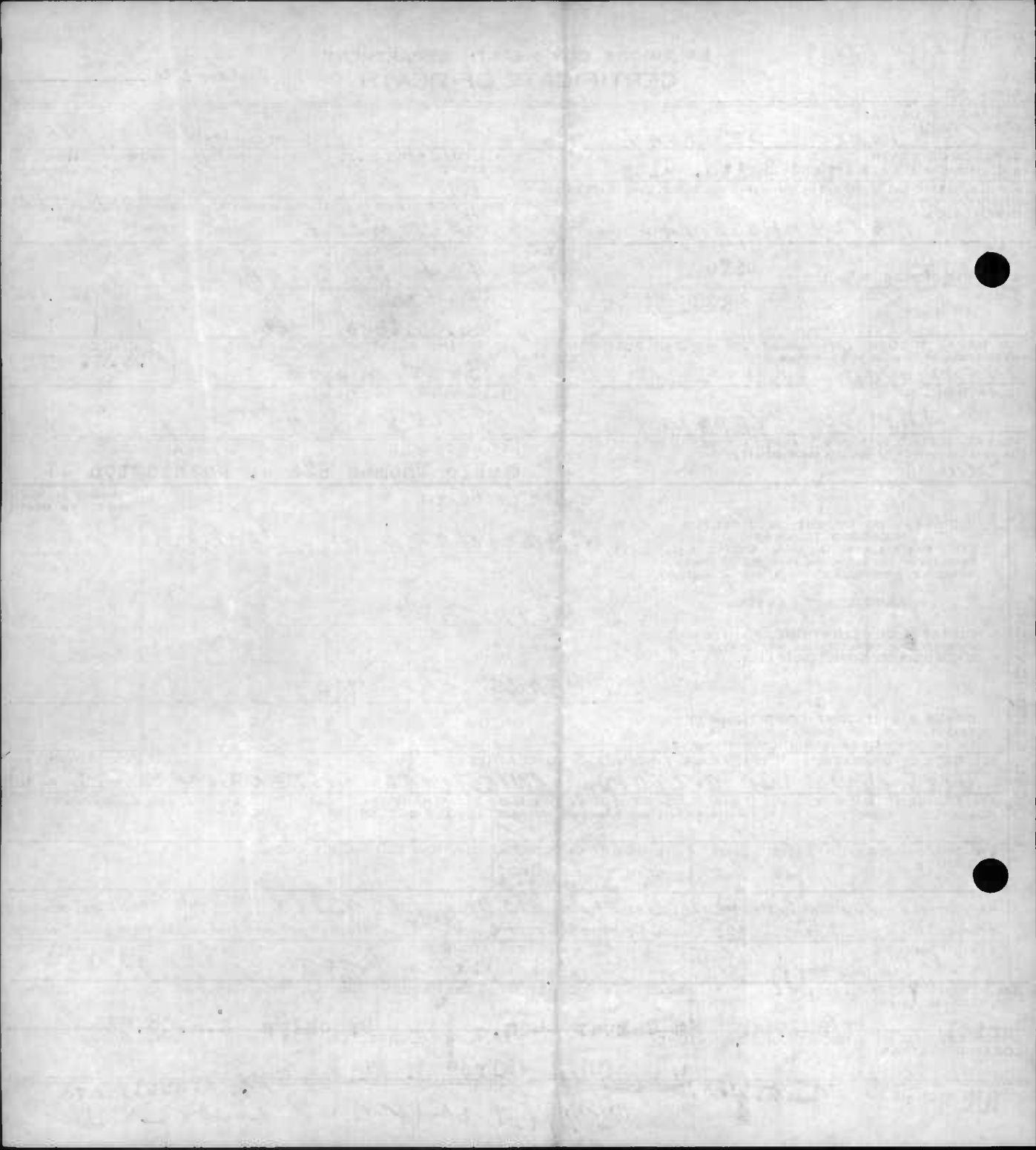
Washington Williams, M.D.

Elroy O. Wilson 1000 Brantly Ave

97099 Elroy O. Wilson

46

MEDICAL CERTIFICATION



00 50 5902

50 5902

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

|  |                                    |   |   |   |   |
|--|------------------------------------|---|---|---|---|
| BIRTH NO. _____  |                                    | 1. NAME OF DECEASED<br>(Type or Print) <i>Lee Nole</i>  |   | 2. DATE OF DEATH<br><i>July 3 1950</i>  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                    | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <i>Md.</i><br>B. COUNTY <i>Baltimore</i><br>C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore</i><br>D. STREET ADDRESS (If rural, give location)<br><i>1921 E. Biddle St. 8-07</i> |   |   |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>1921 E Biddle St.</i>  |                                    | C. LENGTH OF stay in Baltimore <i>30 yrs.</i>   |   |   |   |
| 5. SEX<br><i>Male</i>  | 6. COLOR OR RACE<br><i>Colored</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Married</i>   | 8. DATE OF BIRTH<br><i>June 28 1909</i> | 9. AGE (In years last birthday)<br><i>41</i>  | 10. Under 1 Year Months: Days<br>11. Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Laborer</i>  |                                    | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Baltimore Steel Co.</i>   |   | 11. BIRTHPLACE (State or foreign country)<br><i>S. Carolina</i>                     |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>  |                                    | 13. FATHER'S NAME<br><i>Leora Nole</i>  |   |   |   |
| 14. MOTHER'S MAIDEN NAME<br><i>Margaret Mc Bride</i>   |                                    | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>No.</i>  |   |   |   |
| 16. SOCIAL SECURITY NO.<br><i>1921 E. Biddle St.</i>   |                                    | 17. INFORMANT ADDRESS<br><i>Lee Nole 1921 E. Biddle St.</i>   |   |   |   |
| 18. <i>151X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Carcinoma - stomach and colon.</i>              |                                    | CAUSE OF DEATH<br><i>Carcinoma - stomach and colon.</i>   |   | INTERVAL BETWEEN ONSET AND DEATH<br><i>18 mos</i>                                   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.              |                                    | (A) DUE TO  |   | (B) DUE TO  |   |
| (C) DUE TO   |                                    |   |   |   |   |
| 19A. DATE OF OPERATION<br><i>Jan. 49</i>   |                                    | 19B. MAJOR FINDINGS OF OPERATION<br><i>Carcinoma - stomach &amp; colon</i>  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |                                    | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |   |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   |                                    | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I hereby certify that I attended the deceased from <i>1.23</i> 19 <i>50</i> , to <i>7/3</i> 19 <i>50</i> , that I last saw the deceased alive on <i>7/1</i> 19 <i>50</i> , and that death occurred at <i>9.30</i> pm., from the causes and on the date stated above. |                                    |   |   |   |   |
| 23A. SIGNATURE<br><i>Robert A. Elliott</i>   |                                    | 23B. ADDRESS<br><i>1500 East Madison St. M.D.</i>   |   | 23C. DATE SIGNED<br><i>7-5-50</i>   |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Removal</i>  |                                    | 24B. DATE<br><i>July 6 1950</i>   |   | 24C. NAME OF CEMETERY OR CREMATORY<br><i>St. Stephens S.C.</i>                      |   |
| 24D. LOCATION (City, town, or county) (State)<br><i>St. Stephens S.C.</i>  |                                    | 25. FUNERAL DIRECTOR<br><i>Mrs. Robert A. Elliott, Daughter</i>   |   | ADDRESS<br><i>11297. Caroline St. 46B</i>   |   |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>July 5 1950</i>   |                                    | REGISTRAR'S SIGNATURE<br><i>Wilmington Williams, M.D.</i>   |   | 9703A   |   |

MEDICAL CERTIFICATION

RECEIVED

NOV 10 1964

TO THE PHYSICS DEPARTMENT

FROM THE PHYSICS DEPARTMENT

RE: [illegible]

DATE: [illegible]

BY: [illegible]

FOR: [illegible]

50 5903

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5903

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ALFRED JOSEPH CARTER

2. DATE  
OF  
DEATH

July 4, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

934 Belgian Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE  
Md.C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)

934 Belgian Ave.

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
married

8. DATE OF BIRTH

Nov. 11, 1870

9. AGE (in years  
last birthday)

79

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Proof Reader

10B. KIND OF BUSINESS OR  
INDUSTRY

Printing

11. BIRTHPLACE (State or foreign country)

England

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Annie W. Carter 934 Belgian Ave.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Carcinoma of stomach  
DUE TO with metastasis to liver

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO  
(C)INTERVAL BETWEEN  
ONSET AND DEATH

1 Y.R.

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 1, 1950, to July 4, 1950, that I last saw the  
deceased alive on July 3, 1950, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Lloyd E. Saylor M.D.

23B. ADDRESS

3902 Greenmount Rd. July 5, 1950

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/6/50

24C. NAME OF CEMETERY OR CREMATORY

Greenmount Cem.

24D. LOCATION (City, town, or county) (State)

Balto., Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Thos. J. Dickerson &amp; Sons - Balto. Md.

JUL 5 1950

46 B

MEDICAL CERTIFICATION



STATE OF TEXAS

County of \_\_\_\_\_

My commission expires \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_

at \_\_\_\_\_

Notary Public for the State of Texas

*[Faint handwritten signature]*

NOTARY PUBLIC

(Seal Imprint)

(Circular Stamp)

NOTARY

50 5904

CERTIFICATE CORRECTED 7-12-50

50 5904

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

|  |                                  |   |   |  |  |
|--|----------------------------------|---|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>CLIFTON WELLS MACCUBBIN</b>  |                                  |   | 2. DATE OF DEATH<br><b>July 3, 1950</b>   |  |  |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b><br>B. COUNTY |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION <b>1206 Roundhill Rd.</b>            |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>                          |  |  |
| C. Length of stay in Baltimore   |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>1206 Round Hill Rd.</b>   |  |  |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>married</b> | 8. DATE OF BIRTH<br><b>Jan. 29, 1889</b>  |  | 9. AGE (In years last birthday)<br><b>61</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Assistant Supt. Elec. Div. - Gas &amp; Elec Co</b> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY                                 | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?                 |
| 13. FATHER'S NAME<br><b>Joseph R. Maccubbin</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Cassandra McCubbin</b>   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>066-18-5967</b>                     | 17. INFORMANT ADDRESS<br><b>Mrs. Rosa L. Maccubbin - 1206 Round Hill Rd.</b>  |  |  |

|  |  |   |
|--|--|---|
| 18. <b>356.0</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>BULBAR PARALYSIS</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 WEEKS.</b> |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>HYPERTENSIVE CARDIO-VASCULAR DISEASE</b>  |  | <b>8 YEARS(?)</b>                                   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |   |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 19A. DATE OF OPERATION<br><b>1/0/51</b>  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDER-<br>LYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>INJURY  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>2-1-</b> , 19 <b>50</b> , to <b>7-3-</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>7-3-</b> , 19 <b>50</b> , and that death occurred at <b>3:45 p.m.</b> , from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE<br><i>Arthur K. Karfgen</i>   |  | 23B. ADDRESS<br><b>4230 Loch Raven Blvd</b>   |  | 23C. DATE SIGNED<br><b>7-5-50</b>   |  |

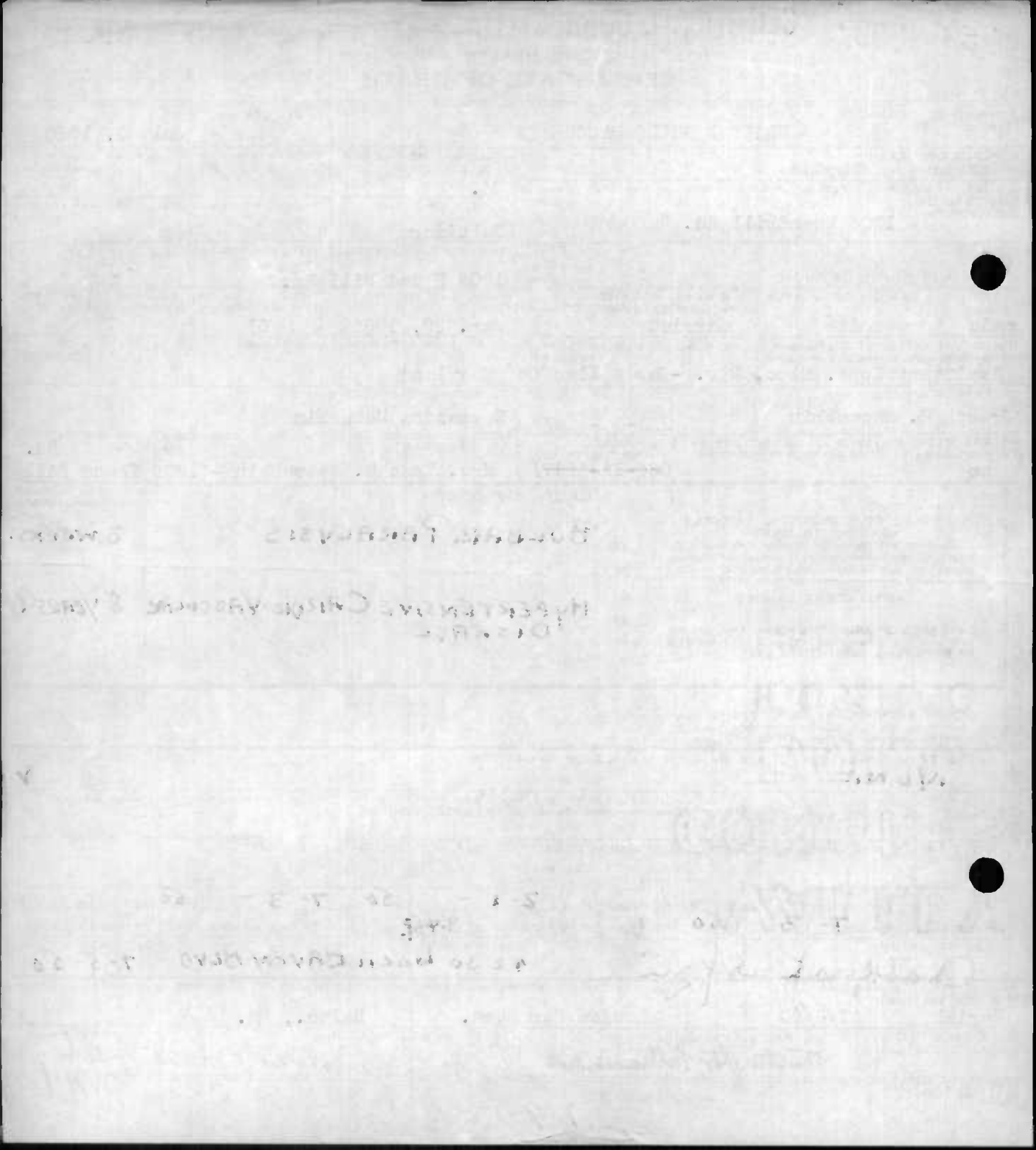
|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> |  | 24B. DATE<br><b>7/6/50</b>                           |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cem.</b>     |  | 24D. LOCATION (City, town, or county) (State)<br><b>Balto., Md.</b> |  |
| DATE RECEIVED BY LOCAL REGISTRAR                           |  | REGISTRAR'S SIGNATURE<br><i>W. J. Williams, M.D.</i> |  | 25. FUNERAL DIRECTOR<br><i>Wm. J. Lickner &amp; Sons - Balto.</i> |  | ADDRESS<br><b>Balto. Md.</b>  |  |

JUL 5 1950

2905E

82

MEDICAL CERTIFICATION



5550 5905

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5905  
Registered No.

BIRTH NO.

|  |                                  |   |  |   |   |
|--|----------------------------------|---|--|---|---|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Roman, Sidney Edward</b>  |                                  |   | 2. DATE OF DEATH<br><b>July 5, 1950</b>  |   |   |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>Bethesda</b> |   |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>U.S. Marine Hospital, Baltimore, Md.</b>                               |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore, Md. Bethesda</b>                         |   |   |
| C. Length of stay in Baltimore   |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>5500 Charles St., Bethesda, Md. 6500</b>   |   |   |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>married</b> | 8. DATE OF BIRTH<br><b>8/11/06</b>   | 9. AGE (In years last birthday)<br><b>43 44</b> | 10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>supply officer</b> |                                  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>NIH, Bethesda, Md.</b>   |   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>New Jersey</b>   |                                  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |   |   |
| 13. FATHER'S NAME<br><b>Wm. Edward Roman</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Minnie Bedmar</b>   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)             |                                  |   | 16. SOCIAL SECURITY NO.  |   |   |
| 17. INFORMANT<br><b>U.S. Marine Hospital, Balto. Md.</b>   |                                  |   | ADDRESS  |   |   |

|  |  |
|--|--|
| 18. <b>420.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Coronary arteriosclerosis and thrombosis with myocardial infarction.</b> | INTERVAL BETWEEN ONSET AND DEATH<br><b>unknown</b> |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>(A) ...</b><br><b>(B) ...</b><br><b>(C) ...</b>   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |

|   |   |  |  |   |  |
|---|---|--|--|---|--|
| 19A. DATE OF OPERATION<br><b>July 1</b>   |   | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |   |  |
| 22. I hereby certify that I attended the deceased from <b>July 1</b> , 19 <b>50</b> , to <b>July 5</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>July 5</b> , 19 <b>50</b> , and that death occurred at <b>9:05 a. m.</b> , from the causes and on the date stated above. |   |  |  |   |  |
| 23A. SIGNATURE<br><b>John L. Wilson, Medical Director</b>   |   | 23B. ADDRESS<br><b>U.S. Marine Hospital, Balto. Md.</b>                  |  | 23C. DATE SIGNED<br><b>7/5/50</b>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   | 24B. DATE<br><b>July 7, 1950</b>  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National Cem.</b>     | 24D. LOCATION (City, town, or county) (State)<br><b>Arlington Va</b> |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR  | REGISTRAR'S SIGNATURE<br><b>Amington Williams, M.D.</b>   | 25. FUNERAL DIRECTOR<br><b>Robert P. Humphrey</b>                        |  | ADDRESS<br><b>Bethesda, Md.</b>   |  |

JUL 5 1950

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50 5906

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

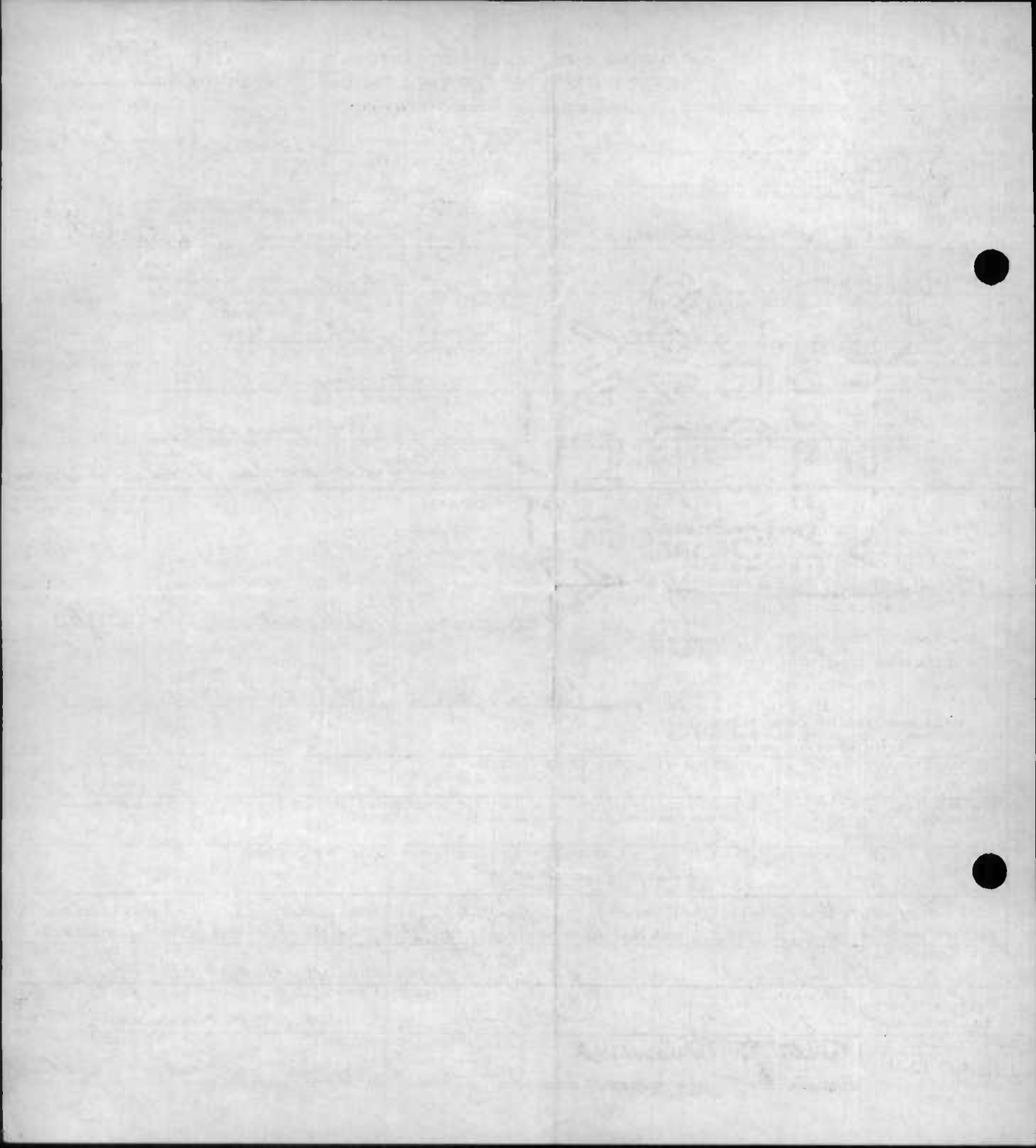
50 5906  
Registered No.

|  |  |
|--|--|
| BIRTH NO.  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>MARY J. MURPHY</b>   |  |
| 2. DATE OF DEATH <b>July 3, 1950</b>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |  |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>md</b> B. COUNTY <b>—</b>             |  |
| 5. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION <b>455 S. Augusta Ave.</b> |  |
| 6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 20-08</b>                                     |  |
| 7. STREET ADDRESS (If rural, give location)<br><b>455 S. Augusta Ave.</b>  |  |
| 8. DATE OF BIRTH <b>Nov. 30, 1873</b>  |  |
| 9. AGE (In years, last birthday) <b>76</b>   |  |
| 10. UNDER 1 Year Months: Days Hours: Min.  |  |
| 11. BIRTHPLACE (State or foreign country) <b>Ireland</b>   |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>   |  |
| 13. FATHER'S NAME <b>Martin Mc Hugh</b>  |  |
| 14. MOTHER'S MAIDEN NAME <b>Verbeuren</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>no</b>   |  |
| 16. SOCIAL SECURITY NO. <b>—</b>   |  |
| 17. INFORMANT ADDRESS <b>214. Patrick J. Murphy 455 S. Augusta Ave</b>   |  |

|   |  |
|---|--|
| 18. <b>290.0</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>(A) Hypostatic Pneumonia</b><br>DUE TO |  |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>(B) Pernicious Anemia</b><br>DUE TO  |  |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>(C) Generalized Atherosclerosis</b>   |  |

|   |  |
|---|--|
| 19A. DATE OF OPERATION <b>0</b>   |  |
| 19B. MAJOR FINDINGS OF OPERATION  |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |  |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |  |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |
| 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>July 2, 1950</b> , to <b>July 3, 1950</b> , that I last saw the deceased alive on <b>July 3, 1950</b> , and that death occurred at <b>4:10 p.m.</b> , from the causes and on the date stated above. |  |
| 23A. SIGNATURE <b>Paul R. Ziegler</b>   |  |
| 23B. ADDRESS <b>3723 Edmondson Ave</b>  |  |
| 23C. DATE SIGNED <b>7/5/50</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   |  |
| 24B. DATE <b>7-6-50</b>   |  |
| 24C. NAME OF CEMETERY OR CREMATORY <b>Cathedral</b>   |  |
| 24D. LOCATION (City, town, or county) (State) <b>Baltimore md</b>   |  |
| 25. FUNERAL DIRECTOR ADDRESS <b>Serge A. Foley 1212 S. 1st St</b>   |  |





520

5907

CERTIFICATE CORRECTED

7-13-50

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5907

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED *Mary*  
(Type or Print)*MRS. VIRGINIA A. KING*2. DATE  
OF  
DEATH*7-5-1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION*ST. Agnes Hospital*Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

5. SEX

*Female*

6. COLOR OR RACE

*white*7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)*single*4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)*Maryland*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Baltimore*

D. STREET ADDRESS (If rural, give location)

*128 W. Franklin St.  
Y.W.C.A. Franklin Park*

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Receptionist*

10B. KIND OF BUSINESS OR INDUSTRY

*East Electric Co*

13. FATHER'S NAME

*Howard V King*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknowns) (If yes, give war or dates of service)

*No.*16. SOCIAL SECURITY NO.  
*219-01-0344*

14. MOTHER'S MAIDEN NAME

*Helen Foll Tull*

17. INFORMANT

ADDRESS

*Mrs. Vernon South, 311 Main Ave.,*

18.

CAUSE OF DEATH

Glen Burnie, Md. INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

*Carcinoma of the body of the pancreas**1 year*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

*Metastases, generalized abdominal**6 mo.*

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

*5/5/50*

19B. MAJOR FINDINGS OF OPERATION

*Generalized abdominal metastases of Carcinoma*

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on *July 5*, 19*50*, and that death occurred at *3:15* AM, from the causes and on the date stated above.

23A. SIGNATURE

*M. M. Conway*

23B. ADDRESS

*St Agnes Hosp. Baltimore 29*

23C. DATE SIGNED

*7/5/50*24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)*Burial*

24B. DATE

*7/6/50*

24C. NAME OF CEMETERY OR CREMATORY

*Chesterfield, Centerville, Md.*

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Wilmington Williams, Md.*

25. FUNERAL DIRECTOR

ADDRESS

*Barton Bros. Centerville, Md.*

VS 150

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468

MEDICAL CERTIFICATION

NEW YORK, N.Y.

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50 5908

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5908

|  |                              |   |   |
|--|------------------------------|---|---|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Beulah Jane Cooke Lowe</b>  |                              | 2. DATE OF DEATH<br><b>7-4-50</b>   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>Baltimore City, Maryland</b>                                      |                              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>Baltimore</b> |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Hospital for the Women of Maryland.</b>                                  |                              | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>  |   |
| C. Length of stay in Baltimore <b>68</b>   |                              | D. STREET ADDRESS (If rural, give location)<br><b>5802 Reed Keisterstown Road.</b>  |   |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>   | 8. DATE OF BIRTH<br><b>July 4, 1882</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>H. W.</b>            |                              | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>   |   |
| 13. FATHER'S NAME<br><b>Charles W. Mason</b>   |                              | 14. MOTHER'S MAIDEN NAME<br><b>Helena Hohenzollern</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No.</b> |                              | 16. SOCIAL SECURITY NO.<br><b>—</b>   |   |
| 17. INFORMANT<br><b>Deceased</b>   |                              | ADDRESS<br><b>The Deceased.</b>   |   |

|   |   |  |
|---|---|--|
| 18. <b>154X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Adenocarcinoma Rectum.</b>           |   | INTERVAL BETWEEN ONSET AND DEATH   |
| DUE TO (A) <b>—</b>   |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO (B) <b>—</b>   |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>DUE TO (C) <b>—</b>  |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>  | 19B. MAJOR FINDINGS OF OPERATION<br><b>—</b>  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)<br><b>none.</b>  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br><b>none</b>  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>—</b> |
| 21D. TIME (Month) (Day) (Year) (Hour)<br><b>—</b>   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?<br><b>—</b>   |
| 22. I hereby certify that I attended the deceased from <b>June 27, 1950</b> , to <b>July 4, 1950</b> , that I last saw the deceased alive on <b>July 3, 1950</b> , and that death occurred at <b>157A</b> m., from the causes and on the date stated above. |   |  |
| 23A. SIGNATURE<br><b>Shelley Roberts Jr. M.D.</b>   | 23B. ADDRESS<br><b>Hospital for the Women of Md.</b>  | 23C. DATE SIGNED<br><b>7-4-50</b>  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>  | 24B. DATE<br><b>7/7/50</b>  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Park</b>                           |
| 24D. LOCATION (City, town or county)<br><b>Baltimore</b>  | 24E. STATE<br><b>Md.</b>  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 6 - 1950</b>   | REGISTRAR'S SIGNATURE<br><b>Wilmington Williams, M.D.</b>   | 25. FUNERAL DIRECTOR<br><b>William Cook</b>  |
| ADDRESS<br><b>1214 St Paul</b>  |   |  |

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

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525  
5909BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5909

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Joseph C. Johnson</i>  |                                  | 2. DATE OF DEATH <i>7-4-50</i>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Maryland</i><br>B. COUNTY |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><i>46 West Balto. Gen. Hosp.</i>     |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Balto. 15-06</i>                            |  |
| C. Length of stay in Baltimore <i>?</i>  |                                  | D. STREET ADDRESS (If rural, give location)<br><i>1608 St Stephen St 16</i>  |  |
| 5. SEX<br><i>MALE</i>  | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>MARRIED</i>  | 8. DATE OF BIRTH<br><i>1-26-80</i>           |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>NIGHT WATCHMAN RETIRED</i> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Western Md Dairy</i>   | 9. AGE (In years last birthday)<br><i>70</i> |
| 13. FATHER'S NAME<br><i>Charles Johnson</i>  |                                  | 11. BIRTHPLACE (State or foreign country)<br><i>BALTO Co Md</i>  | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>UNK</i>        |                                  | 16. SOCIAL SECURITY NO.<br><i>?</i>  | 17. INFORMANT<br><i>Wife</i>                 |
|  |                                  | ADDRESS<br><i>SAME</i>   |  |

|  |   |                                  |
|--|---|----------------------------------|
| 18. <i>451X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | CAUSE OF DEATH<br>(A) <i>Ruptured Aneurysm of Aorta</i><br>DUE TO<br>(B) <i>Aneurysm - dissecting of Aorta</i><br>DUE TO<br>(C) <i>Possibly on luetic basis (not proved)</i><br><br><i>Cardiac tamponade.</i> | INTERVAL BETWEEN ONSET AND DEATH |
|--|---|----------------------------------|

|  |   |   |
|--|---|---|
| 19A. DATE OF OPERATION<br><i>7-4-50</i>      | 19B. MAJOR FINDINGS OF OPERATION  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |

22. I hereby certify that I attended the deceased from *1 July*, 1950, to *4 July*, 1950, that I last saw the deceased alive on *7-4*, 1950, and that death occurred at *8:50* p.m., from the causes and on the date stated above.

|  |  |                                   |
|--|--|-----------------------------------|
| 23A. SIGNATURE<br><i>John C. Hyle MD</i> | 23B. ADDRESS<br><i>West Balto Gen Hosp</i> | 23C. DATE SIGNED<br><i>7-5-50</i> |
|--|--|-----------------------------------|

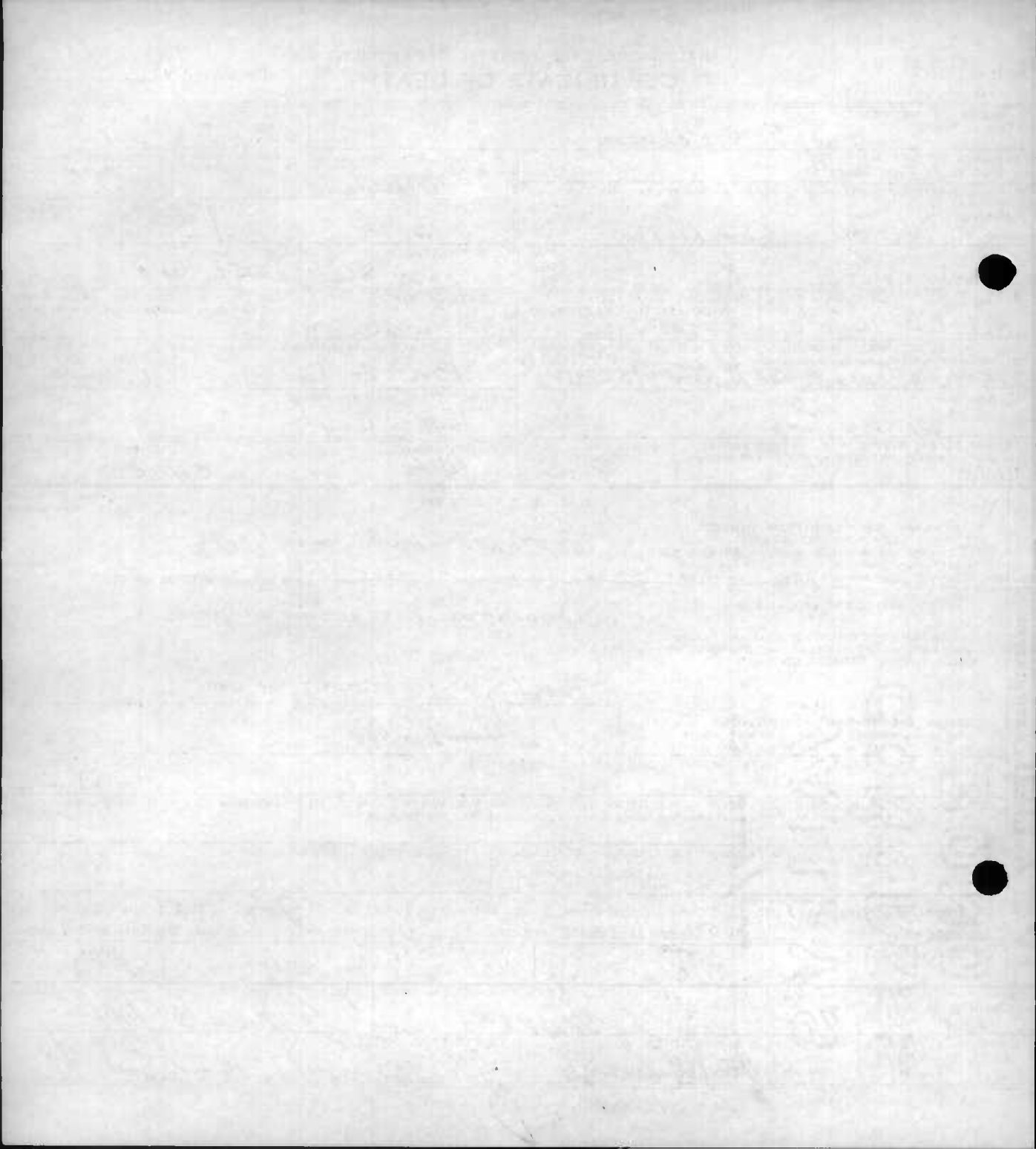
|  |                            |   |  |
|--|----------------------------|---|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>burial</i> | 24B. DATE<br><i>7/9/50</i> | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Parkwood</i> | 24D. LOCATION (City, town, or county) (State)<br><i>Parkville Md</i> |
|--|----------------------------|---|--|

|   |   |  |                                   |
|---|---|--|-----------------------------------|
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUL 6 - 1950</i> | REGISTRAR'S SIGNATURE<br><i>Thurston Williams, M.D.</i> | 25. FUNERAL DIRECTOR<br><i>Mr. J. A. Davis</i> | ADDRESS<br><i>1214 St Paul St</i> |
|---|---|--|-----------------------------------|

76341

309





536  
50 5910BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5910

|   |                           |   |                                   |
|---|---------------------------|---|-----------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) FRANK B SNYDER   |                           | 2. DATE OF DEATH July 4, 1950   |                                   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                           | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland<br>B. COUNTY   |                                   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>Franklin Square Hospital   |                           | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 19-02   |                                   |
| D. Length of stay in Baltimore<br>Yrs. Mos. Days  |                           | E. STREET ADDRESS (If rural, give location)<br>113 N. Stricker Street   |                                   |
| 5. SEX<br>Male  | 6. COLOR OR RACE<br>White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Widowed  | 8. DATE OF BIRTH<br>Jan 12-1868   |
| 9. AGE (In years last birthday)<br>82   |                           | 10. Under 1 Year<br>Months: Days  | 11. Under 24 Hours<br>Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)<br>Lawn Mower  |                           | 10B. KIND OF BUSINESS OR INDUSTRY<br>Swindell Bros  |                                   |
| 11. BIRTHPLACE (State or foreign country)<br>Baltimore Md   |                           | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |                                   |
| 13. FATHER'S NAME<br>George Snyder  |                           | 14. MOTHER'S MAIDEN NAME<br>Mary (Johnson)  |                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br>No   |                           | 16. SOCIAL SECURITY NO.<br>None   |                                   |
| 17. INFORMANT<br>Arlene J. Tomczak  |                           | ADDRESS<br>2403 Cordell   |                                   |
| 18. E972 X<br>CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>(A) Carbon monoxide poisoning<br>DUE TO<br>ANTECEDENT CAUSES<br>(B)<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(C)<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                           |   |                                   |
| 19A. DATE OF OPERATION  |                           | 19B. MAJOR FINDINGS OF OPERATION  |                                   |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                           |   |                                   |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                           | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br>Home   |                                   |
| 21C. WHERE DID INJURY OCCUR?<br>113 N. Stricker Street  |                           |   |                                   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY<br>July 4, 1950 1:15 P. m.  |                           | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                                   |
| 21F. HOW DID INJURY OCCUR?<br>8 burners on stove open but unlit   |                           |   |                                   |
| 22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input checked="" type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .   |                           |   |                                   |
| 23A. SIGNATURE<br>Stanley B. Neulacher, M.D.  |                           | 23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/> |                                   |
| 23C. DATE SIGNED<br>July 5, 1950  |                           |   |                                   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                           | 24B. DATE<br>7/7/50   |                                   |
| 24C. NAME OF CEMETERY OR CREMATORY<br>Landon Park   |                           | 24D. LOCATION (City, town, or county) (State)<br>Baltimore Md   |                                   |
| DATE RECEIVED BY LOCAL REGISTRAR<br>JUL 6 - 1950  |                           | REGISTRAR'S SIGNATURE<br>Huntington Williams, M.D.  |                                   |
| 25. FUNERAL DIRECTOR<br>J. W. Lee   |                           | ADDRESS<br>1217 St. Paul St   |                                   |

MEDICAL CERTIFICATION

STATE OF NEW YORK  
CERTIFICATE OF DEATH

For use in New York City

NAME OF DECEASED

AGE

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Coroner

Signature of Registrar

Signature of Burial Officer

Signature of Minister of Religion

Signature of Undertaker

Signature of Witness

Signature of Burial Officer

Signature of Registrar

Signature of Coroner

Signature of Physician

Signature of Burial Officer

Signature of Registrar

Signature of Coroner

Signature of Physician

Signature of Burial Officer

Signature of Registrar

Signature of Coroner

Signature of Physician

Signature of Burial Officer

Signature of Registrar

Signature of Coroner

Signature of Physician

Signature of Burial Officer

Signature of Registrar

Signature of Coroner

Signature of Physician

Signature of Burial Officer

Signature of Registrar

Signature of Coroner

Signature of Physician

Signature of Burial Officer

Signature of Registrar

Signature of Coroner

Signature of Physician

Signature of Burial Officer

Signature of Registrar

Signature of Coroner

620  
50 5911BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5911

|  |                           |  |                                  |
|--|---------------------------|--|----------------------------------|
| BIRTH NO.  |                           | 2. DATE OF DEATH<br>July 4, 1950   |                                  |
| 1. NAME OF DECEASED<br>(Type or Print)<br>Mary Blanche Price   |                           | 2. DATE OF DEATH<br>July 4, 1950   |                                  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                           | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY |                                  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>Southern Hospital   |                           | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 20-01                      |                                  |
| C. Length of stay in Baltimore<br>Yrs. Mos. Days   |                           | D. STREET ADDRESS (If rural, give location)<br>526 N. Fulton Ave.  |                                  |
| 5. SEX<br>Female   | 6. COLOR OR RACE<br>White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Widow   | 8. DATE OF BIRTH<br>Feb 22, 1868 |
| 9. AGE (In years last birthday)<br>82  |                           | 10. UNDER 1 Year Months Days<br>11. UNDER 24 Hours Hours Min.  |                                  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife   |                           | 10B. KIND OF BUSINESS OR INDUSTRY<br>At Home   |                                  |
| 11. BIRTHPLACE (State or foreign country)<br>Frederick, Md.  |                           | 12. CITIZEN OF WHAT COUNTRY?   |                                  |
| 13. FATHER'S NAME<br>David K. Zollickoffer   |                           | 14. MOTHER'S MAIDEN NAME<br>Unknown  |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br>No  |                           | 16. SOCIAL SECURITY NO.  |                                  |
| 17. INFORMANT<br>Archie K. Price, Essex, Md.   |                           | ADDRESS  |                                  |
| 18. 422.1<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br>Cerebral Thrombosis<br>DUE TO<br>Arteriosclerosis<br>DUE TO<br>Chronic Myocarditis<br>DUE TO<br>Old Age<br>INTERVAL BETWEEN ONSET AND DEATH<br>2 yrs.<br>several years<br>4 mo |                           |  |                                  |
| 19A. DATE OF OPERATION<br>0  |                           | 19B. MAJOR FINDINGS OF OPERATION   |                                  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                           |  |                                  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |                           | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                            |                                  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                           |  |                                  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>INJURY  |                           | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>            |                                  |
| 21F. HOW DID INJURY OCCUR?   |                           |  |                                  |
| 22. I hereby certify that I attended the deceased from May 10, 1950, to July 4, 1950, that I last saw the deceased alive on July 3, 1950, and that death occurred at m., from the causes and on the date stated above.   |                           |  |                                  |
| 23A. SIGNATURE<br>Shirley P. Blake M. D.   |                           | 23B. ADDRESS<br>Med arts Bldg.   |                                  |
| 23C. DATE SIGNED<br>7-5-50   |                           |  |                                  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |                           | 24B. DATE<br>7/6/50  |                                  |
| 24C. NAME OF CEMETERY OR CREMATORY<br>Ft. Lincoln  |                           | 24D. LOCATION (City, town, or county) (State)<br>Prince George Co., Md.  |                                  |
| DATE RECEIVED BY LOCAL REGISTRAR<br>JUL 6 - 1950   |                           | REGISTRAR'S SIGNATURE<br>Huntington Williams, M.D.   |                                  |
| FUNERAL DIRECTOR<br>J. M. Cook   |                           | ADDRESS<br>1214 St Paul St   |                                  |

44115A

CENTRAL INTELLIGENCE AGENCY

REPORT OF SPECIAL AGENT IN CHARGE

TO THE DIRECTOR, CENTRAL INTELLIGENCE AGENCY

FROM THE SPECIAL AGENT IN CHARGE

SUBJECT: [Illegible]

DATE: [Illegible]

CLASSIFICATION: [Illegible]

REFERENCE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

624  
5912BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5912

BIRTH NO. 50-10962

1. NAME OF DECEASED  
(Type or Print)

LEROY MARSHALL

2. DATE  
OF  
DEATH

6-2-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

39 Provident Hospital

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

1 1/2

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

11-04

D. STREET ADDRESS (If rural, give location)

911 Madison Ave

8. DATE OF BIRTH

6-1-50

9. AGE (In years last birthday)

11 Under 1 Year  
Months: Days  
1 5

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Joseph Marshall

14. MOTHER'S MAIDEN NAME

Thelma Rutledge

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Birth Certificate

18. 760.0 I

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) .....  
DUE TO

Atherosclerosis

1 1/2 days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) .....  
DUE TO

Coronary Arteriosclerosis

1 1/2 days

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) .....  
DUE TO

Pulmonary Embolism

1 1/2 days

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-1, 1950, to 6-2, 1950, that I last saw the deceased alive on 6-2, 1950, and that death occurred at 12:35 m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

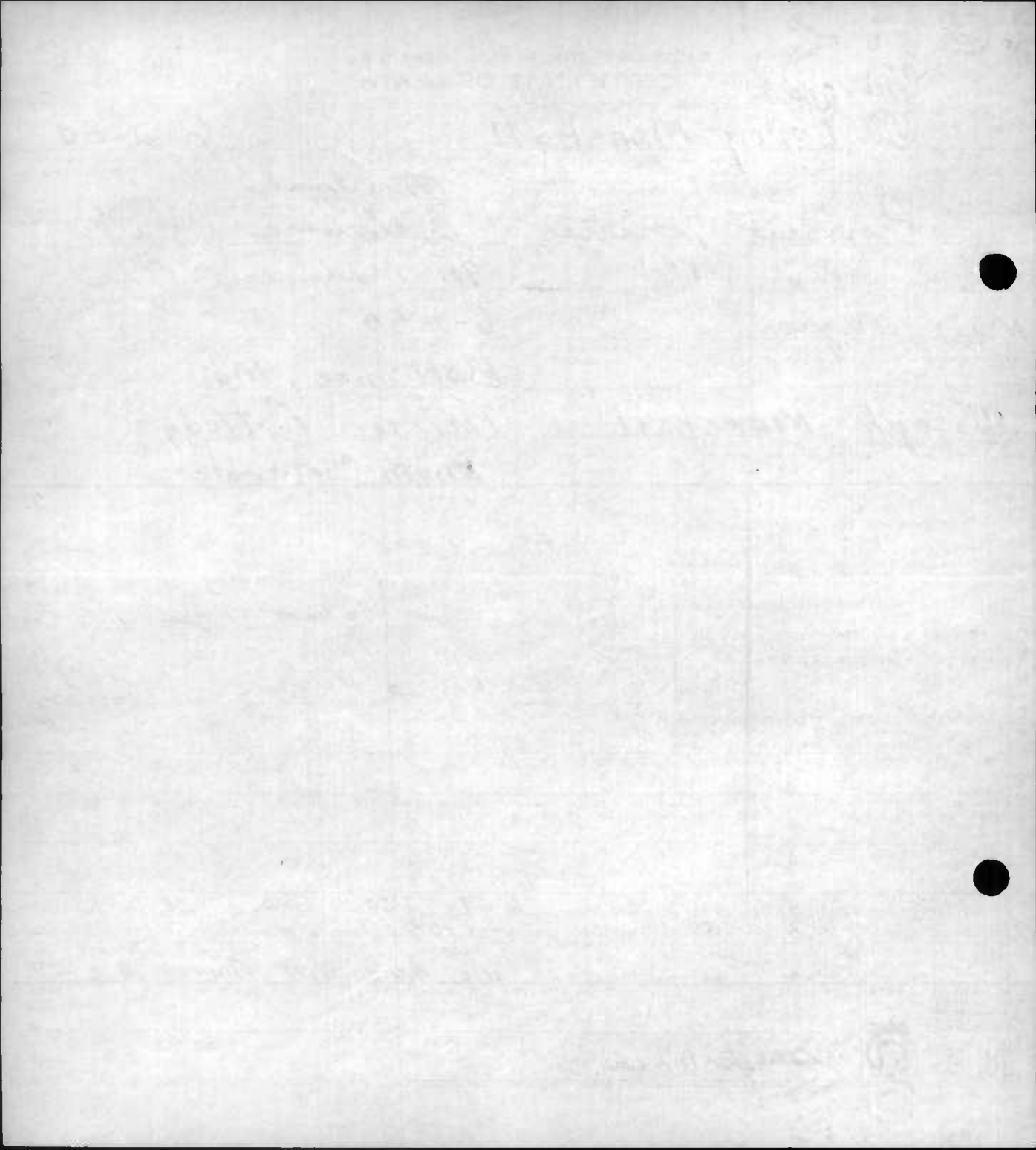
JUL 6 - 1950

Thurston Williams, M.D.

1100 Druid Hill Ave

7-1-50





520

5913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

5913

Registered No.

BIRTH NO. 50-4655

1. NAME OF DECEASED (Type or Print)

2. DATE OF DEATH

3. PLACE OF DEATH:

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

18. 776 X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/4 1950, to 6/5 1950, that I last saw the deceased alive on 6/5 1950, and that death occurred at 8:25 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

25. FUNERAL DIRECTOR ADDRESS

VS 150

159

MEDICAL CERTIFICATION

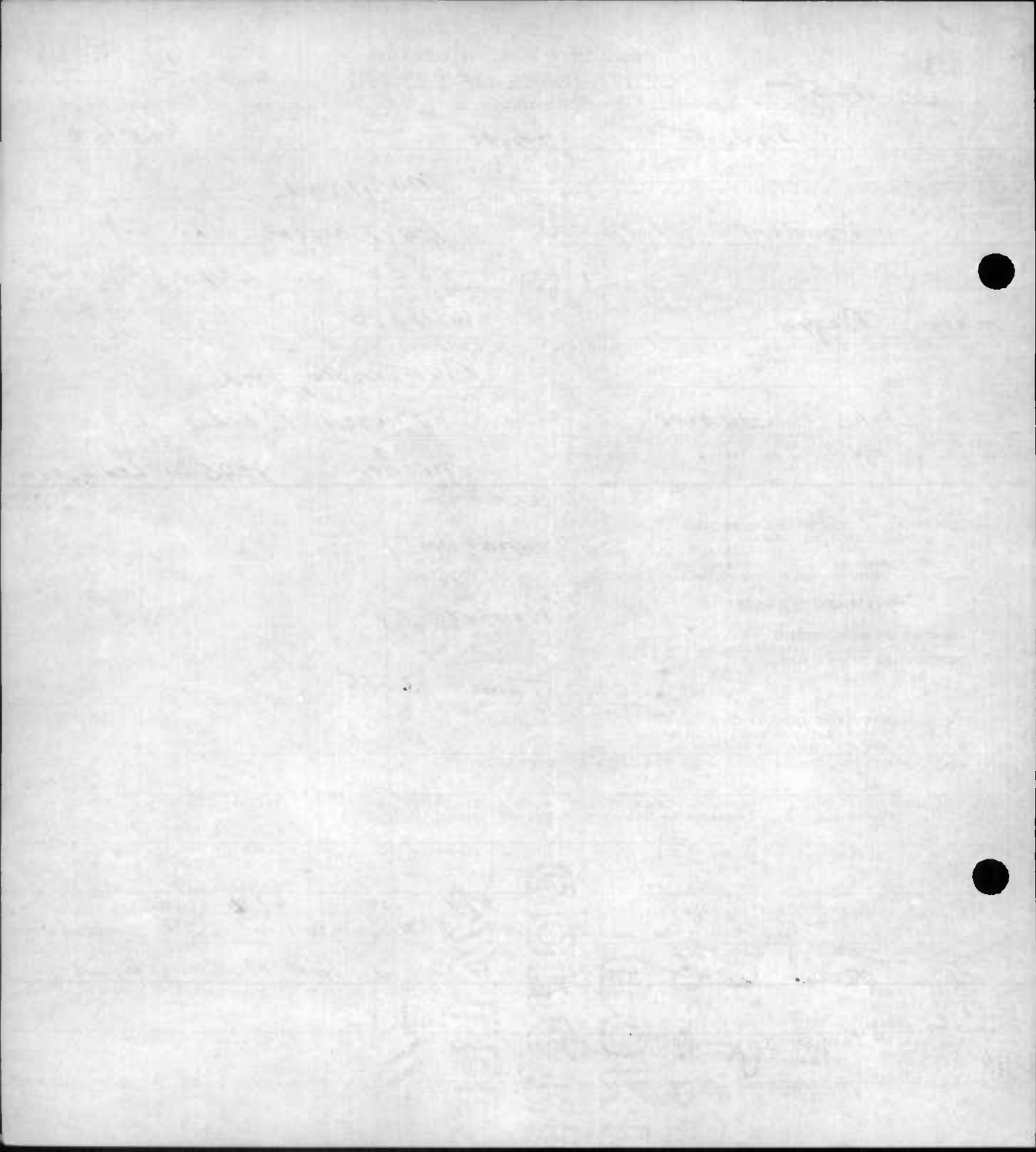
used by Provident Hosp.

DATE RECEIVED BY LOCAL REGISTRAR  
JUL 6 - 1950

REGISTRAR'S SIGNATURE  
Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS



520

0 5914

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5914

BIRTH NO. 50-11656

1. NAME OF DECEASED  
(Type or Print)

Infant

Jamer II

2. DATE  
OF  
DEATH

6-4-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Provident Hospital

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Baltimore 20-01

D. STREET ADDRESS (If rural, give location)

1835 W. Lexington

5. SEX

8. DATE OF BIRTH

6/4/50

9. AGE (in years, last birthday)

10 Under 1 Year  
Months: Days  
11 Under 24 Hours  
Hours: Min.

4 18

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Jamer

14. MOTHER'S MAIDEN NAME

Nancy Carey

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mother

ADDRESS

1835 W. Lexington

18. 776X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Immaturity

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Prematurity

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Twin Birth

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6 PM 6/4/50, to 6/4/50, that I last saw the deceased alive on 6/4/50, and that death occurred at 10:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

1100 N. Hill Ave.

6/29/50

24A. BURIAL, CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

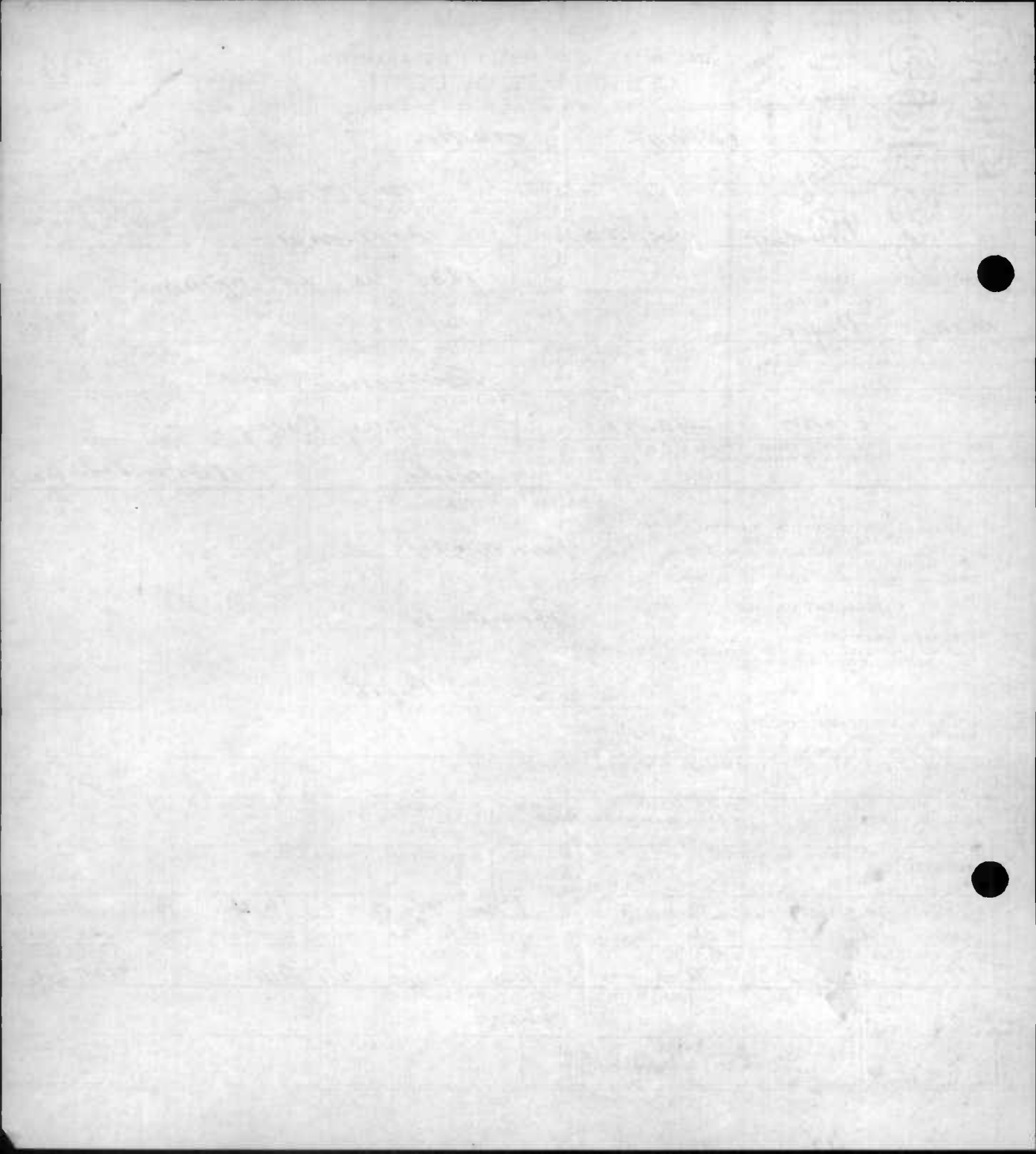
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 6 - 1950

Huntington Williams, M.D.



| 650   |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | 50 5915  |  |
|---|--|---|--|--|--|
| 0 REA-139307  |  | CERTIFICATE OF DEATH  |  | Registered No.   |  |
| BIRTH NO. 50-12897  |  |   |  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print)  |  | 2. DATE OF DEATH  |  | June 28, 1950  |  |
| Baby Boy Brown-Mary   |  |   |  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)     |  |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)  |  | A. STATE  |  | Maryland   |  |
| Baltimore City Hospitals  |  | B. COUNTY   |  |  |  |
| 4940 Eastern Avenue   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)              |  | Baltimore  |  |
| C. Length of stay in Baltimore  |  | D. STREET ADDRESS (If rural, give location)   |  | 2509 Madison Avenue - 17   |  |
| Life  |  |   |  |  |  |
| 5. SEX  |  | 6. COLOR OR RACE  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)                          |  |
| Male  |  | Negro   |  | Single   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 8. DATE OF BIRTH   |  |
|   |  |   |  | June 28, 1950  |  |
| 13. FATHER'S NAME   |  | 14. MOTHER'S MAIDEN NAME  |  | 9. AGE (In years last birthday)  |  |
| Leonard Brown   |  | Mary Thomas   |  | If Under 1 Year Months: Days   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.   |  | 11. BIRTHPLACE (State or foreign country)                                |  |
|   |  |   |  | Maryland   |  |
|   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?   |  |
|   |  |   |  | 1  |  |
|   |  |   |  | 17. INFORMANT  |  |
|   |  |   |  | Baltimore City Hospitals   |  |
|   |  |   |  | Records: 4940 Eastern Avenue   |  |
| 18. 774 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                        |  | CAUSE OF DEATH  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| (A) Prematurity and Anoxia  |  | DUE TO  |  |  |  |
| ANTECEDENT CAUSES   |  | (B)   |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  | DUE TO  |  |  |  |
| (C)   |  |   |  |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |   |  |  |  |
| 19A. DATE OF OPERATION  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?   |  |
| 2   |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME (Month) (Day) (Year) (Hour)   |  | 21E. INJURY OCCURRED  |  | 21F. HOW DID INJURY OCCUR?   |  |
| INJURY  |  | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>         |  |  |  |
| 22. I hereby certify that I attended the deceased from June 28, 1950, to June 28, 1950 that I last saw the deceased alive on June 28, 1950, and that death occurred at 10:55 Pm., from the causes and on the date stated above. |  |   |  |  |  |
| 23A. SIGNATURE  |  | 23B. ADDRESS  |  | 23C. DATE SIGNED   |  |
| [Signature]   |  | M. D. 4940 Eastern Avenue   |  | 7-1-50   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   |  | 24B. DATE   |  | 24C. NAME OF CEMETERY OR CREMATORY                                       |  |
| Cremation   |  | June 30, 1950   |  | B. C. H. Crematory   |  |
| DATE RECEIVED BY LOCAL REGISTRAR  |  | REGISTRAR'S SIGNATURE   |  | 24D. LOCATION (City, town, or county) (State)                            |  |
| JUL 6 - 1950  |  | [Signature]   |  | Baltimore, Maryland  |  |
|   |  | 25. FUNERAL DIRECTOR  |  | ADDRESS  |  |
|   |  |   |  |  |  |



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CENTRAL BANK OF INDIA

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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

50 5916

150  
BIRTH NO. 5916

|  |   |   |  |
|--|---|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>MARY DEVINE</b>  |   | 2. DATE OF DEATH <b>July 3, 1950</b>  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>City</b>   |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Provident Hospital</b>   |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>  |  |
| C. Length of stay in Baltimore <b>25</b> Yrs. Mos. Days  |   | D. STREET ADDRESS (If rural, give location)<br><b>555 W. Biddle Street</b>  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>Colored</b>                        | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Single</b>  | 8. DATE OF BIRTH<br><b>??/1857</b>                                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>  | 9. AGE (In years last birthday)<br><b>93</b>                           |
| 11. BIRTHPLACE (State or foreign country)<br><b>S. C.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |
| 13. FATHER'S NAME<br><b>unknown</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>unknown</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>no</b>   | 16. SOCIAL SECURITY NO.<br><b>none</b>                    | 17. INFORMANT ADDRESS<br><b>Rev. Nora P. Samuel - Biddle St.</b>  |  |
| 18. <b>422.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic cardiovascular disease</b>  |   |   | INTERVAL BETWEEN ONSET AND DEATH                                       |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B) _____<br>(C) _____   |   |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>_____   |   |   |  |
| 19A. DATE OF OPERATION   |   | 19B. MAJOR FINDINGS OF OPERATION  |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |   | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |   | 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |  |
| 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that I took charge of the remains described above, held an <u>Inspection &amp; Inquiry</u> thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <u>natural causes</u> <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |   |   |  |
| 23A. SIGNATURE<br><b>P. S. Fisher</b>  |   | 23B. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> M.D. MEDICAL INVESTIGATOR..... <input type="checkbox"/> |  |
| 23C. DATE SIGNED<br><b>July 3, 1950</b>  |   |   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  | 24B. DATE<br><b>7/7/50</b>                                | 24C. NAME OF CEMETERY OR CREMATORY<br><b>mt Calvary</b>   | 24D. LOCATION (City, town, or county) (State)<br><b>Cedar Hill Md.</b> |
| DATE RECEIVED BY LOCAL REGISTRAR   | REGISTRAR'S SIGNATURE<br><b>Wilmington Williams, M.D.</b> | 25. FUNERAL DIRECTOR ADDRESS<br><b>A. Halstead - 918 - Lincoln Hill, Md.</b>  |  |

MEDICAL CERTIFICATION

JUL 6 1950

19  
CERTIFICATE OF DEATH  
FALLING FROM A HEIGHT OF 100 FEET

DEATH OF DEATH

150

50 5917

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5917

Registered No.

|  |                               |   |   |
|--|-------------------------------|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>CHARLES H. HEVINE</b>  |                               | 2. DATE OF DEATH <b>7-5-50</b>  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                               | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Md</b> B. COUNTY |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>117 No Broadway</b>   |                               | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 6-05</b>                 |   |
| C. Length of stay in Baltimore <b>life</b>   |                               | D. STREET ADDRESS (If rural, give location)<br><b>117 No Broadway</b>   |   |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>   | 8. DATE OF BIRTH                          |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>manager</b>   |                               | 10B. KIND OF BUSINESS OR INDUSTRY <b>Clothing (r)</b>   | 9. AGE (In years last birthday) <b>50</b> |
| 11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>  |                               | 12. CITIZEN OF WHAT COUNTRY?  |   |
| 13. FATHER'S NAME <b>Mordeca</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>Edith</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |                               | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT <b>Young Levine</b>  |                               | ADDRESS <b>117 No Broadway</b>  |   |
| 18. <b>420.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Myocardial Infarction</b><br>DUE TO<br><b>Coronary Sclerosis</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                               | INTERVAL BETWEEN ONSET AND DEATH  |   |
| 19A. DATE OF OPERATION <b>0</b>  |                               | 19B. MAJOR FINDINGS OF OPERATION  |   |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                               |   |   |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |                               | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                             |   |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                               | 21D. HOW DID INJURY OCCUR?  |   |
| 21E. TIME (Month) (Day) (Year) (Hour) INJURY   |                               | 21F. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                |   |
| 22. I hereby certify that I attended the deceased from <b>3/4</b> <b>1950</b> to <b>7/5</b> , 1950, that I last saw the deceased alive on <b>7/3</b> , 1950, and that death occurred at <b>6</b> <b>PM</b> , from the causes and on the date stated above.   |                               |   |   |
| 23A. SIGNATURE <b>Charles H. Hevine</b>  |                               | 23B. ADDRESS <b>3123 Eastern Ave</b>  |   |
| 23C. DATE SIGNED <b>7/6/50</b>   |                               |   |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 24B. DATE <b>7-6-50</b>   |   |
| 24C. NAME OF CEMETERY OR CREMATORY <b>Rosedale</b>   |                               | 24D. LOCATION (city, town, or county) <b>Balto Md</b>   |   |
| DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 6 - 1950</b>   |                               | REGISTRAR'S SIGNATURE <b>Winston Williams, M.D.</b>   |   |
| FUNERAL DIRECTOR <b>Jack Lewis Inc</b>   |                               | ADDRESS <b>2100 Eastern Pl</b>  |   |

MEDICAL CERTIFICATION

Flower  
3123 Eastern Ave  
10-17-11

THE  
NATIONAL  
BOND  
CORPORATION

351

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5918

BIRTH NO. 50 5918

|   |                                  |   |   |  |   |
|---|----------------------------------|---|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>CHEVA STOMBLER</b>  |                                  |   | 2. DATE OF DEATH <b>7-5-50</b>  |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md</b> B. COUNTY |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b> Sinai Hospital</b>   |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 15-11</b>                |  |   |
| C. Length of stay in Baltimore<br><b>20</b> Yrs. <b>20</b> Mos. <b>20</b> Days                                  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>3228 Sequoia Ave</b>  |  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b> | 8. DATE OF BIRTH<br><b>7-5-18</b>   |  | 9. AGE (In years, last birthday)<br><b>32</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY                                 |   | 11. BIRTHPLACE (State or foreign country)<br><b>Russia</b> |   |
| 13. FATHER'S NAME<br><b>Mendel</b>  |                                  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>Russia</b>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)   |                                  |   | 16. SOCIAL SECURITY NO.   |  |   |
| 17. INFORMANT<br><b>David Stompler</b>  |                                  |   | ADDRESS<br><b>3704 Harrington Rd</b>  |  |   |

|  |  |                                       |  |                                  |  |
|--|--|---------------------------------------|--|----------------------------------|--|
| 18. <b>331X I</b>  |  | CAUSE OF DEATH                        |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) |  | (A) <b>Cerebrovascular accident</b>   |  |                                  |  |
| DUE TO   |  |                                       |  |                                  |  |
| ANTECEDENT CAUSES  |  | (B) <b>Arteriosclerosis, cerebral</b> |  |                                  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  | DUE TO                                |  |                                  |  |
| II   |  | (C) <b>Pneumonia ?</b>                |  |                                  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |                                       |  |                                  |  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 19A. DATE OF OPERATION <b>0</b>   |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>July 5, 1950</b> , to <b>July 5, 1950</b> , that I last saw the deceased alive on <b>July 5, 1950</b> , and that death occurred at <b>1:35 P.m.</b> , from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE<br><b>Altman</b>   |  | 23B. ADDRESS<br><b>M. O. Sinai Hospital</b>   |  | 23C. DATE SIGNED<br><b>July 5, 1950</b>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>7-6-50</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Rosedale</b>                               |  |
| 24D. LOCATION (City, town, or county)<br><b>Balto Md</b>  |  | 24E. DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 6 - 1950</b>  |  | 24F. REGISTRAR'S SIGNATURE<br><b>Thurston Williams</b>                              |  |
| 24G. FUNERAL DIRECTOR<br><b>Jack Lewis</b>  |  | 24H. ADDRESS<br><b>2100 Canton Rd</b>   |  |   |  |





230

5919

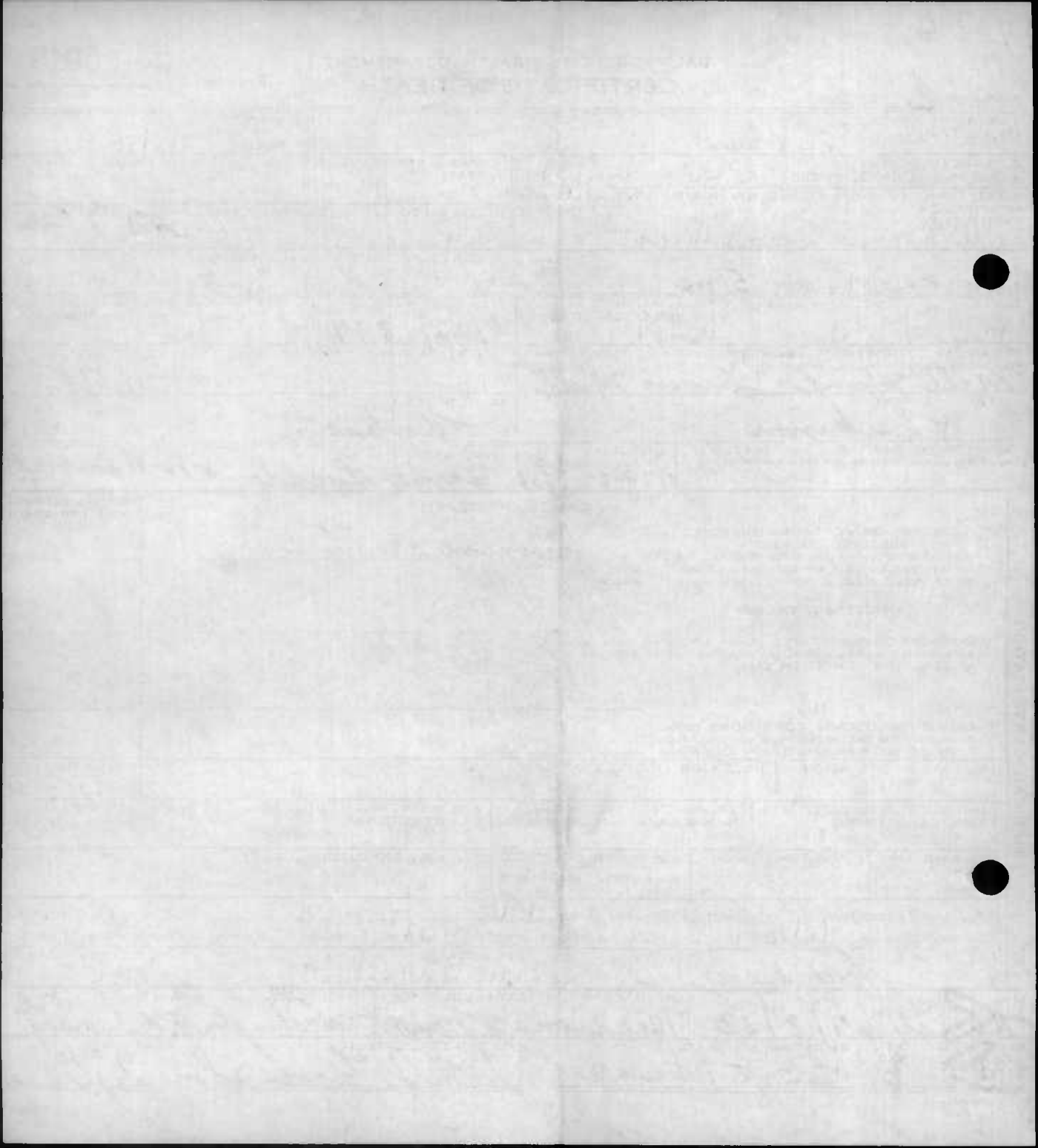
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5919

Registered No.

|   |                                  |   |   |  |                                  |
|---|----------------------------------|---|---|--|----------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Fred Lucado</b>   |                                  |   | 2. DATE OF DEATH<br><b>7/5/50</b>   |  |                                  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>Baltimore, Maryland</b>  |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>Baltimore</b> |  |                                  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>South Baltimore General Hospital</b>  |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)<br><b>Baltimore</b>   |  |                                  |
| C. Length of stay in Baltimore <b>5 yrs</b>   |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>110 W. Lombard Street</b>   |  |                                  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>   | 8. DATE OF BIRTH<br><b>6/22/1897</b>  | 9. AGE (In years last birthday)<br><b>53</b>   | 10. Under 1 Year<br>Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired)<br><b>Mill Hand</b>   |                                  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Grain Mill</b>  |  |                                  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>  |                                  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |                                  |
| 13. FATHER'S NAME<br><b>Unknown</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>-</b>   |                                  |   | 16. SOCIAL SECURITY NO.<br><b>719-079001</b>  |  |                                  |
| 17. INFORMANT<br><b>Garrie Lucado</b>   |                                  |   | ADDRESS<br><b>810 W. Lombard St.</b>  |  |                                  |
| 18. <b>470.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cornary thrombosis</b>               |                                  |   | INTERVAL BETWEEN ONSET AND DEATH  |  |                                  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>II</b>   |                                  |   |   |  |                                  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                                  |   |   |  |                                  |
| 19A. DATE OF OPERATION<br><b>0</b>  |                                  | 19B. MAJOR FINDINGS OF OPERATION  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |                                  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)               |                                  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>INJURY   |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |                                  |
| 22. I hereby certify that I attended the deceased from <b>7/5/50</b> , 19__, to <b>7/5/50</b> , 19__, that I last saw the deceased alive on <b>7/5/50</b> , 19__, and that death occurred at <b>8:21 A.M.</b> , from the causes and on the date stated above. |                                  |   |   |  |                                  |
| 23A. SIGNATURE<br><b>S. Rodriguez</b>   |                                  | 23B. ADDRESS<br><b>1213 N. Light Street</b>   |   | 23C. DATE SIGNED<br><b>7/5/50</b>  |                                  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 24B. DATE<br><b>7/8/50</b>  |   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Mem. Pk. Washington Rd Dorsey</b> |                                  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 6-1950</b>   |                                  | REGISTRAR'S SIGNATURE<br><b>John J. Lawrence</b>  |   | FUNERAL DIRECTOR<br><b>John J. Lawrence</b>  |                                  |
| VS 150  |                                  | 696 43  |   | 94a St.  |                                  |

MEDICAL CERTIFICATION



152  
50 5920BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5920  
Registered No.

|   |                           |  |                                  |  |                              |
|---|---------------------------|--|----------------------------------|--|------------------------------|
| BIRTH NO.   |                           | 1. NAME OF DECEASED<br>(Type or Print)<br>ALMA APPELGARTH CHAVANNES (MRS. FRANK S.)  |                                  | 2. DATE OF DEATH<br>JULY 5, 1950   |                              |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                           | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE MARYLAND B. COUNTY BALTIMORE |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>BALTIMORE (18) 12-02 |                              |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>THE UNION MEMORIAL HOSPITAL  |                           | D. STREET ADDRESS (If rural, give location)<br>3507 N. CHARLES ST.   |                                  |  |                              |
| C. Length of stay in Baltimore<br>73  |                           | Yrs. Mos. Days   |                                  |  |                              |
| 5. SEX<br>FEMALE  | 6. COLOR OR RACE<br>WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>MARRIED   | 8. DATE OF BIRTH<br>MAY 20, 1877 | 9. AGE (In years last birthday)<br>73  | 10. Under 1 Year Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>HOUSEWIFE  |                           | 10B. KIND OF BUSINESS OR INDUSTRY<br>at home   |                                  | 11. BIRTHPLACE (State or foreign country)<br>MARYLAND  |                              |
| 12. CITIZEN OF WHAT COUNTRY?<br>USA   |                           | 13. FATHER'S NAME<br>CHARLES L. APPELGARTH   |                                  | 14. MOTHER'S MAIDEN NAME<br>LAURA V. PEARSON   |                              |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br>UNKNOWN  |                           | 16. SOCIAL SECURITY NO.  |                                  | 17. INFORMANT<br>FRANK S. CHAVANNES  |                              |
| 18. 443X  |                           | CAUSE OF DEATH   |                                  | ADDRESS<br>3507 N. CHARLES ST.<br>BALTO. 18 MD.  |                              |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>DUE TO<br>(A) CEREBRAL HEMORRHAGE<br>15 MIN. |                           |  |                                  |  |                              |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO<br>(B) HYPERTENSIVE CARDIOVASCULAR DISEASE<br>5 YEARS  |                           |  |                                  |  |                              |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>(C) Anterior Rhinovirus  |                           |  |                                  |  |                              |
| 19A. DATE OF OPERATION<br>0   |                           | 19B. MAJOR FINDINGS OF OPERATION   |                                  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  |                              |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                           | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                                      |                                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                             |                              |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |                           | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                      |                                  | 21F. HOW DID INJURY OCCUR?   |                              |
| 22. I hereby certify that I attended the deceased from <del>July 5</del> Jan 5, 1950 to JULY 5, 1950, that I last saw the deceased alive on JULY 5, 1950, and that death occurred at 2:25 P.m., from the causes and on the date stated above.   |                           |  |                                  |  |                              |
| 23A. SIGNATURE<br>J. H. Chatham   |                           | 23B. ADDRESS<br>15 E. Balto. St.   |                                  | 23C. DATE SIGNED<br>July 3/50  |                              |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                           | 24B. DATE<br>7/8/50  |                                  | 24C. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cem.   |                              |
| 24D. LOCATION (City, town, or county) (State)<br>Pikesville, Md.  |                           | DATE RECEIVED BY LOCAL REGISTRAR<br>JUL 6 - 1950   |                                  | REGISTRAR'S SIGNATURE<br>Huntington Williams, M.D.   |                              |
| 25. FUNERAL DIRECTOR<br>J. J. Dickerson & Sons, Balto. Md.  |                           | ADDRESS  |                                  |  |                              |

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1901

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1900

ALBANY:

ANDREW D. DODD, PRINTERS

1901

425  
50 5921  
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5921

|   |                                  |   |   |  |   |
|---|----------------------------------|---|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>MARY NELSON</b>   |                                  |   | 2. DATE OF DEATH <b>July 5, 1950</b>  |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Md.</b><br>B. COUNTY |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>3506 Ellerslie Ave.</b>   |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>9-03</b>              |  |   |
| C. Length of stay in Baltimore<br>Yrs.<br>Mos.<br>Days  |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>3506 Ellerslie Ave.</b>   |  |   |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>widowed</b> | 8. DATE OF BIRTH<br><b>Aug. 15, 1879</b>  | 9. AGE (In years last birthday)<br><b>70</b> | 10. Under 1 Year Months: Days<br>11. Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>       |                                  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>at home</b>   |  |   |
| 13. FATHER'S NAME<br><b>- Vanik</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b> |                                  |   | 16. SOCIAL SECURITY NO.<br><b>none</b>  |  |   |
| 17. INFORMANT   |                                  |   | ADDRESS<br><b>Miss Florence Nelson - 3506 Ellerslie Av</b>  |  |   |

|   |   |
|---|---|
| 18. <b>420.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>CORONARY THROMBOSIS</b><br>DUE TO<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>PARALYSIS FLGITANS</b><br>DUE TO<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>ARTERIO SCLEROSIS - GENERAL</b><br><b>12 ED</b> | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>3 YEARS (!)</b><br><b>10 YEARS.</b> |
|---|---|

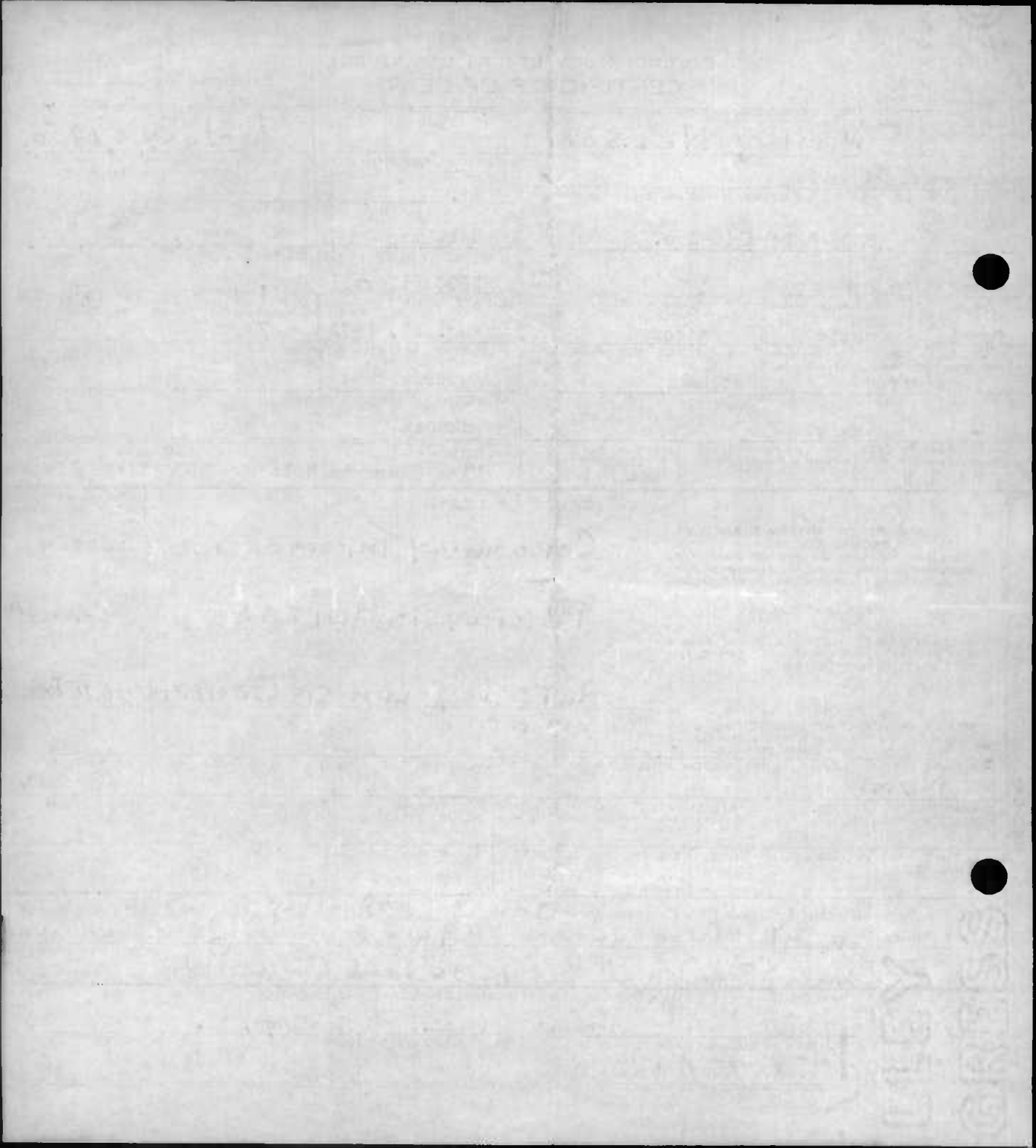
|  |   |   |
|--|---|---|
| 19A. DATE OF OPERATION<br><b>NONE</b>        | 19B. MAJOR FINDINGS OF OPERATION  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY | 21E. INJURY OCCURRED<br>WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK | 21F. HOW DID INJURY OCCUR?  |

22. I hereby certify that I attended the deceased from **OCT.**, 1949 to **July 5, 1950**, that I last saw the deceased alive on **6-27**, 1950, and that death occurred at **9 a. m.**, from the causes and on the date stated above.

|  |   |  |
|--|---|--|
| 23A. SIGNATURE<br><b>Carlton R. Ruffin</b> M. D.           | 23B. ADDRESS<br><b>4230 Loch Raven Blvd</b>               | 23C. DATE SIGNED<br><b>7-5-50</b>                                  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24B. DATE<br><b>7/8/50</b>                                | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cem.</b>    |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 6 - 1950</b>    | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b> | 25. FUNERAL DIRECTOR<br><b>St. M. J. Dickens &amp; Sons - Balt</b> |
| VS 150   |   | ADDRESS<br><b>Woodlawn, Md.</b>                                    |

94a





1660  
5922  
138659  
BIRTH NO.

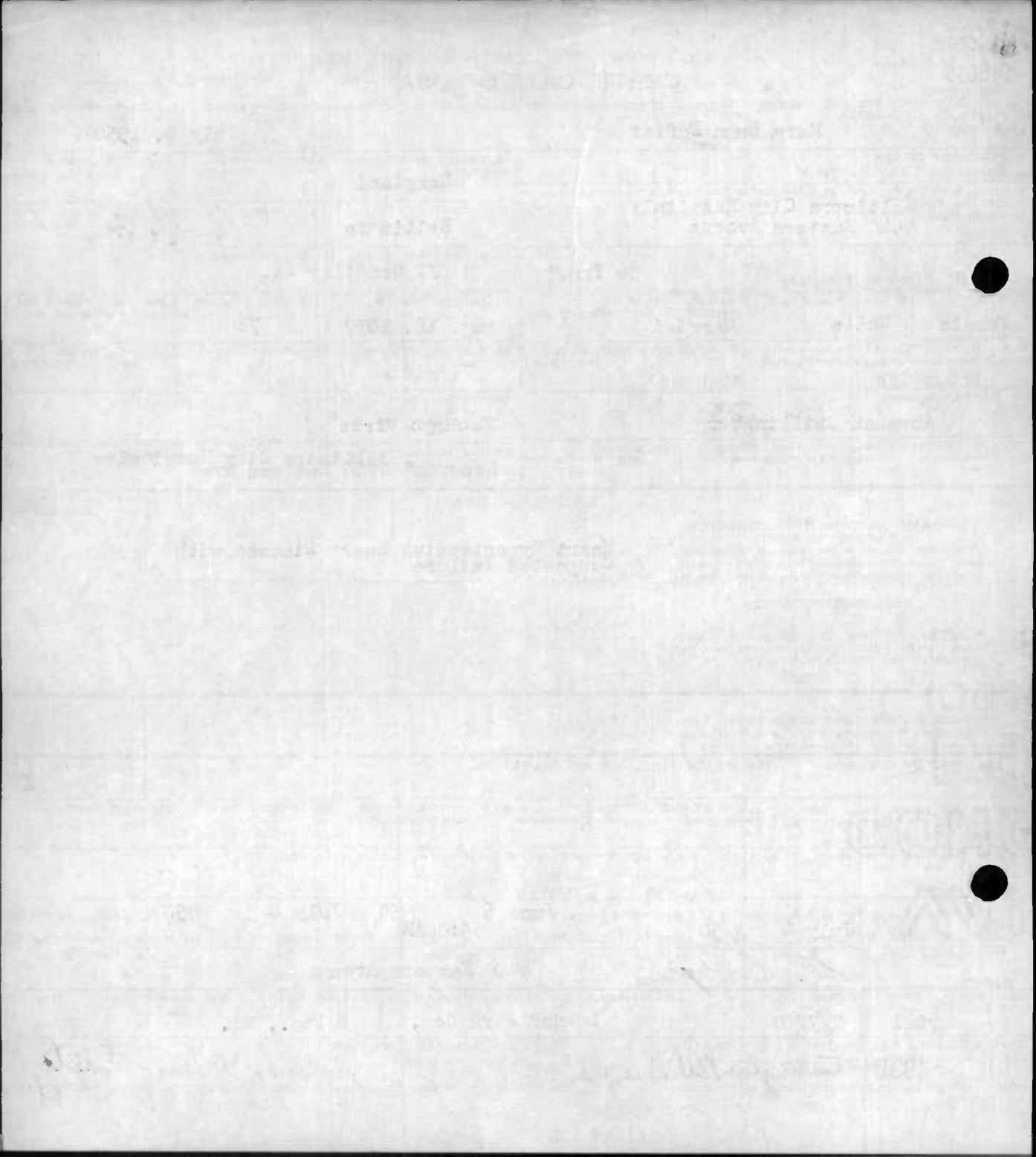
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5922

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Mary Emma Daffer</b>   |  |  | 2. DATE OF DEATH<br><b>July 4, 1950</b>  |  |  |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b><br>B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>Baltimore City Hospitals</b><br><b>4940 Eastern Avenue</b>  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY<br>C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b><br>D. STREET ADDRESS (If rural, give location)<br><b>627 Grantley St.</b> |  |  |
| 5. SEX <b>Female</b>   |  |  | 6. COLOR OR RACE <b>White</b>  |  |  |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>  |  |  | 8. DATE OF BIRTH<br><b>Aug. 18, 1877</b>   |  |  |
| 9. AGE (In years last birthday)<br><b>72</b>   |  |  | 10. UNDER 1 Year Months: Days<br>11. UNDER 24 Hours Hours: Min.  |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>at home</b>  |  |  |
| 13. FATHER'S NAME<br><b>Abraham Shillingberg</b>   |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Kathryn Virts</b>   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>-</b>  |  |  | 16. SOCIAL SECURITY NO.  |  |  |
| 17. INFORMATION<br><b>Baltimore City Hospitals</b><br><b>Records* 4940 Eastern Ave</b>   |  |  |  |  |  |
| 18. <b>443 X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Heart Hypertensive Heart Disease with Congested Failure</b><br>DUE TO<br>(A) <b>Heart Hypertensive Heart Disease with Congested Failure</b><br>(B)<br>(C)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B)<br>(C)<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| 19A. DATE OF OPERATION<br><b>0</b>   |  |  | 19B. MAJOR FINDINGS OF OPERATION   |  |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  |  |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   |  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |
| 21F. HOW DID INJURY OCCUR?   |  |  |  |  |  |
| 22. I hereby certify that I attended the deceased from <b>June 6, 1950</b> , to <b>July 4, 1950</b> , that I last saw the deceased alive on <b>July 4, 1950</b> , and that death occurred at <b>5:00 AM</b> , from the causes and on the date stated above.  |  |  |  |  |  |
| 23A. SIGNATURE<br><b>R. Rogers</b>   |  |  | 23B. ADDRESS<br><b>4940 Eastern Avenue</b>   |  |  |
| 23C. DATE SIGNED   |  |  |  |  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  | 24B. DATE<br><b>7/7/50</b>   |  |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cem.</b>  |  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Balto., Md.</b>  |  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 6 - 1950</b>  |  |  | REGISTRAR'S SIGNATURE<br><b>Wm. J. Dickener &amp; Sons</b>   |  |  |
| VS 150   |  |  | 25. FUNERAL DIRECTOR<br><b>Wm. J. Dickener &amp; Sons</b>  |  |  |
|  |  |  | ADDRESS<br><b>Balto. Md.</b>   |  |  |

MEDICAL CERTIFICATION

937

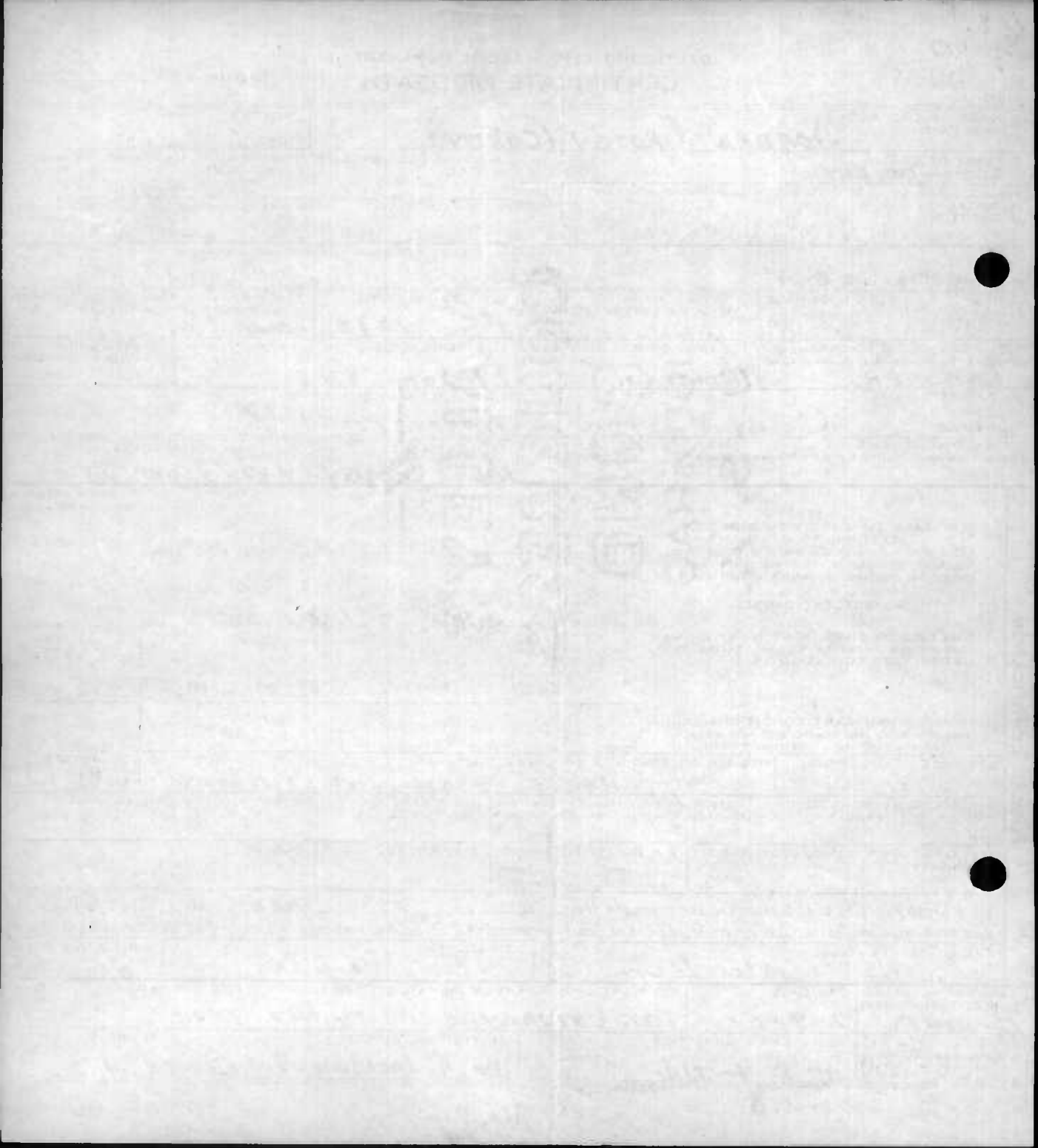


621  
210  
50 5923

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5923

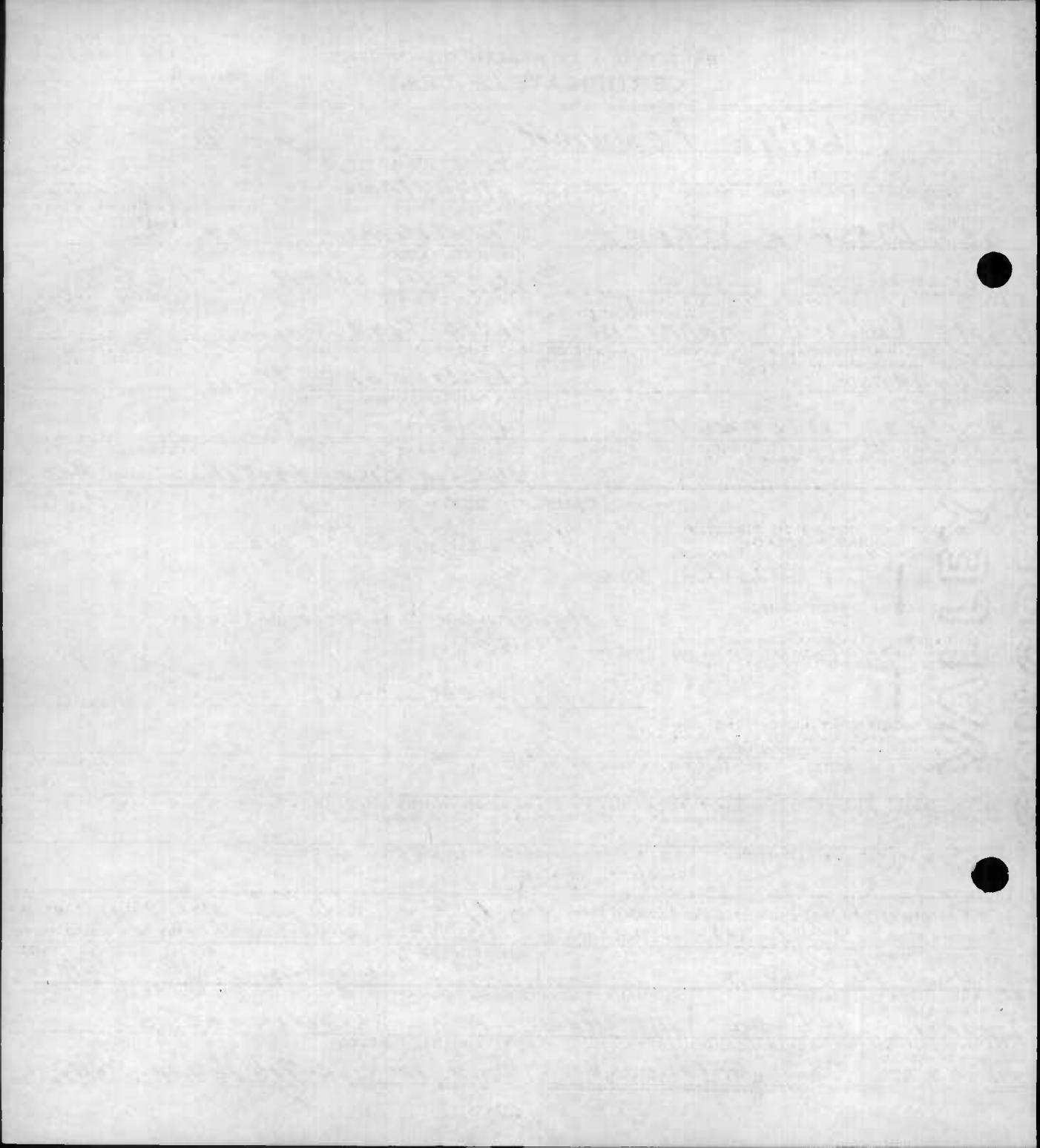
|  |   |  |   |
|--|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>JORDAN N. CROSBY (CROSBY)</b>  |   | 2. DATE OF DEATH <b>7/3/50</b>   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |   | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>UNIVERSITY HOSPITAL</b>  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTIMORE 4-01</b>  |   |
| C. Length of stay in Baltimore   |   | D. STREET ADDRESS (If rural, give location)<br><b>427 TYSON STREET</b>   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>NEGRO</b>  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>MARRIED</b>  | 8. DATE OF BIRTH<br><b>1- -1888</b>   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>LABORER</b>  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>INDUSTRIAL</b>   | 9. AGE (In years last birthday)<br><b>62</b>  |
| 13. FATHER'S NAME<br><b>DAVID CROSBY</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>ELISON, VA.</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)  |   | 12. CITIZEN OF WHAT COUNTRY?   |   |
| 16. SOCIAL SECURITY NO.  |   | 14. MOTHER'S MAIDEN NAME<br><b>HARRIETT ?</b>  |   |
| 17. INFORMANT<br><b>PEARL CROSBY</b>   |   | ADDRESS<br><b>-427 TYSON ST.</b>   |   |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>150X I</b><br>(A) <b>PULMONARY EMBOLOSION(?)</b><br>DUE TO<br>ANTECEDENT CAUSES<br>(B) <b>CORONARY ESOPHAGEOUS</b><br>DUE TO<br>(C) <b>Post-OPERATIVE GASTROSTOMY</b><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1/2 hour</b><br><b>5 days</b>                |
| 19A. DATE OF OPERATION<br><b>6/25/50</b>   | 19B. MAJOR FINDINGS OF OPERATION<br><b>IN OPERABLE Esophageal Carcinoma</b>                               |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |   |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>INJURY  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <b>7/1</b> , 19 <b>50</b> to <b>7/3/50</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>July 2nd, 1950</b> , and that death occurred at <b>3:50</b> m., from the causes and on the date stated above.  |   |  |   |
| 23A. SIGNATURE<br><b>Charles T. Henderson</b>  |   | 23B. ADDRESS<br><b>UNIV. Hospital</b>  | 23C. DATE SIGNED<br><b>7/3/50</b>   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 24B. DATE<br><b>7-8-50.</b>   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>MT. CALVARY</b>   | 24D. LOCATION (City, town, or county) (State)<br><b>A. A. Co. Mo.</b>               |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 6 - 1950</b>  |   | REGISTRAR'S SIGNATURE<br><b>Wm. A. Jackson</b>   | 25. FUNERAL DIRECTOR<br><b>Wm. A. JACKSON - 916 PENNA. AVE.</b>                     |



520  
50 5924BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5924  
Registered No.

|   |                                    |   |                                      |
|---|------------------------------------|---|--------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>LILLIE FENWICK</b>  |                                    | 2. DATE OF DEATH <b>7-2-50.</b>   |                                      |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                    | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND.</b><br>B. COUNTY |                                      |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>632 MOSHER STREET</b>   |                                    | C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)<br><b>BALTIMORE 17.</b>                           |                                      |
| C. Length of stay in Baltimore <b>LIFE</b>  |                                    | D. STREET ADDRESS (If rural, give location)<br><b>632 MOSHER STREET</b>   |                                      |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>COLORED</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>MARRIED</b>   | 8. DATE OF BIRTH<br><b>4-16-1898</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>LAUNDRESS</b>   |                                    | 9. AGE (In years last birthday) <b>62</b><br>If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.                      |                                      |
| 10B. KIND OF BUSINESS OR INDUSTRY<br><b>LAUNDRY</b>   |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE, MD.</b>  |                                      |
| 13. FATHER'S NAME<br><b>CHARLES STEPNEY</b>   |                                    | 12. CITIZEN OF WHAT COUNTRY?  |                                      |
| 14. MOTHER'S MAIDEN NAME<br><b>AMELIA ?</b>   |                                    | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                        |                                      |
| 16. SOCIAL SECURITY NO.   |                                    | 17. INFORMANT ADDRESS<br><b>AMELIA RICE - 1805 MADISON AVE.</b>   |                                      |
| 18. <b>442 X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>CONGESTIVE FAILURE</b><br>DUE TO<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>HYPERTENSIVE CARDIO-VASCULAR DISEASE</b><br><b>NEPHROSCLEROSIS</b> |                                    | INTERVAL BETWEEN ONSET AND DEATH  |                                      |
| 19A. DATE OF OPERATION <b>0</b>   |                                    | 19B. MAJOR FINDINGS OF OPERATION  |                                      |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                    |   |                                      |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                                    | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                                       |                                      |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                                    |   |                                      |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |                                    | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                       |                                      |
| 21F. HOW DID INJURY OCCUR?  |                                    |   |                                      |
| 22. I hereby certify that I attended the deceased from <b>July 4, 1950</b> , to <b>July 2, 1950</b> , that I last saw the deceased alive on <b>July 1, 1950</b> , and that death occurred at <b>4:30 A. M.</b> , from the causes and on the date stated above.  |                                    |   |                                      |
| 23A. SIGNATURE<br><b>Dr. H. C. [Signature]</b>  |                                    | 23B. ADDRESS<br><b>1115 Pennsylvania Ave.</b>   |                                      |
| 23C. DATE SIGNED<br><b>7/6/50</b>   |                                    |   |                                      |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                    | 24B. DATE<br><b>7-6-50.</b>   |                                      |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>MT. AUBURN</b>   |                                    | 24D. LOCATION (City, town, or county) (State)<br><b>BALTIMORE, 30.</b>  |                                      |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 6 - 1950</b>   |                                    | REGISTRAR'S SIGNATURE<br><b>Wm. A. Jackson</b>  |                                      |
| 25. FUNERAL DIRECTOR<br><b>Wm. A. JACKSON - 916 PENNA. AVE.</b>   |                                    | ADDRESS   |                                      |





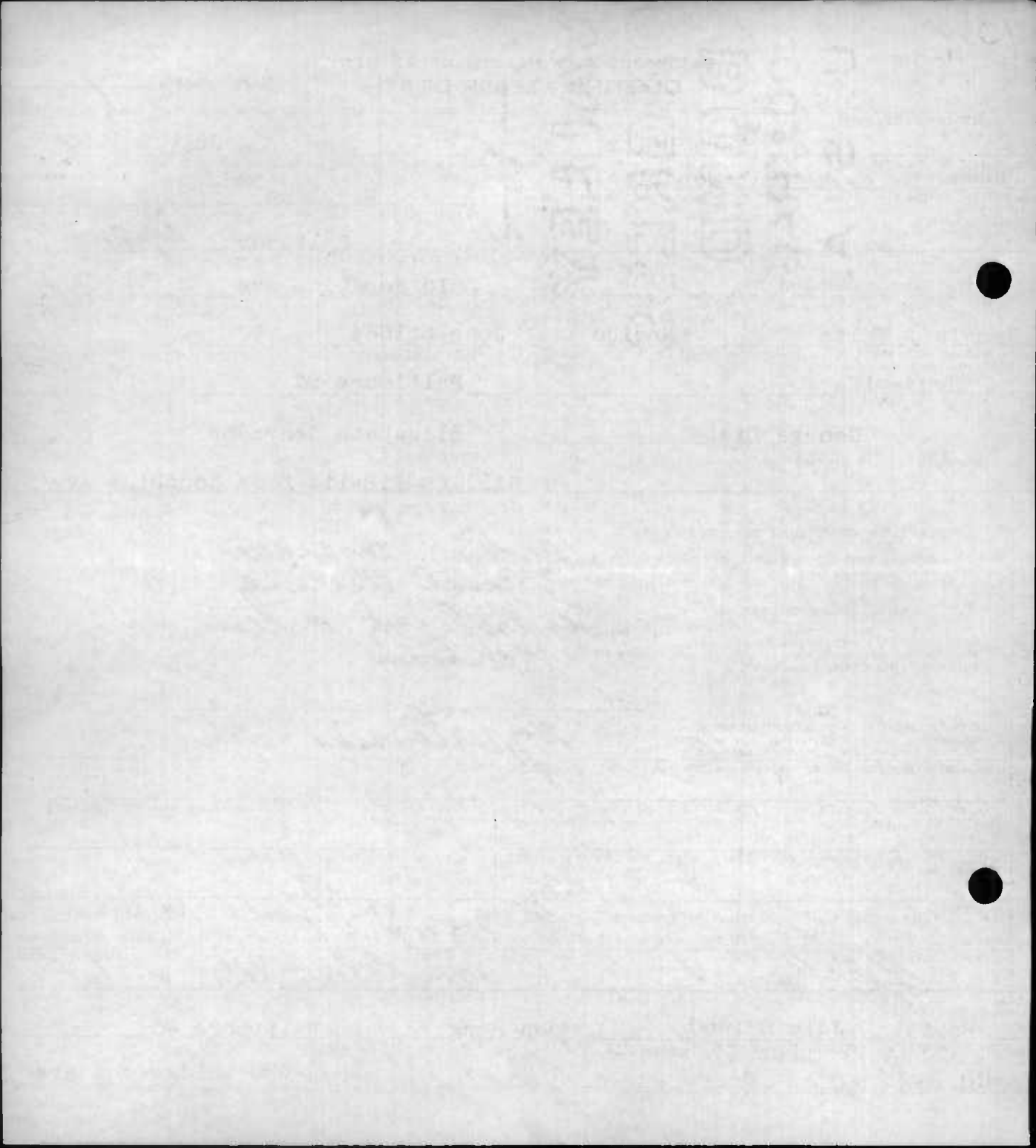
432  
50 5925

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5925  
Registered No.

|  |                           |  |                                 |  |  |
|--|---------------------------|--|---------------------------------|--|--|
| BIRTH NO.  |                           | 1. NAME OF DECEASED<br>(Type or Print)   |                                 | 2. DATE OF DEATH   |  |
|  |                           | Mary Baltz   |                                 | July 5 1950  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland 3813 Woodbine Ave  |                           | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE Maryland B. COUNTY |                                 |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION  |                           | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 28-01                      |                                 |  |  |
| C. Length of stay in Baltimore Life Yrs. Mos. Days   |                           | D. STREET ADDRESS (If rural, give location)<br>3813 Woodbine Ave   |                                 |  |  |
| 5. SEX<br>Female   | 6. COLOR OR RACE<br>White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Married   | 8. DATE OF BIRTH<br>June 2 1884 | 9. AGE (In years last birthday)<br>66                                    | If Under 1 Year Months Days If Under 24 Hours Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife   |                           | 10B. KIND OF BUSINESS OR INDUSTRY  |                                 | 11. BIRTHPLACE (State or foreign country)<br>Baltimore Md                |  |
| 13. FATHER'S NAME<br>George Dietel   |                           | 14. MOTHER'S MAIDEN NAME<br>Elizabeth Schrader   |                                 | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |                           | 16. SOCIAL SECURITY NO.  |                                 | 17. INFORMANT ADDRESS<br>William F. Baltz 3813 Woodbine Ave              |  |
| 18. 442x I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)                   |                           | CAUSE OF DEATH   |                                 | INTERVAL BETWEEN ONSET AND DEATH   |  |
| ANTECEDENT CAUSES  |                           | (A) Cardio-vascular renal disease  |                                 |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |                           | (B) Generalized arteriosclerosis   |                                 |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                           | (C) Hypertension   |                                 |  |  |
| 19A. DATE OF OPERATION 0   |                           | 19B. MAJOR FINDINGS OF OPERATION   |                                 | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |                           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                             |                                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   |                           | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK               |                                 | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from May 1949, to June 5, 1950, that I last saw the deceased alive on 7/5, 1950, and that death occurred at 2:57 p.m., from the causes and on the date stated above. |                           |  |                                 |  |  |
| 23A. SIGNATURE<br>J. Holanick  |                           | 23B. ADDRESS<br>4710 Liberty St  |                                 | 23C. DATE SIGNED<br>7/6/50   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |                           | 24B. DATE<br>July 8 1950   |                                 | 24C. NAME OF CEMETERY OR CREMATORY<br>Loudon Park                        |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br>JUL 6 - 1950   |                           | REGISTRAR'S SIGNATURE<br>Harry D. Winick   |                                 | 25. FUNERAL DIRECTOR ADDRESS<br>4204 Ridgewood Ave                       |  |

MEDICAL CERTIFICATION



32  
0 5926

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5926  
Registered No.

|   |                                  |  |   |   |  |
|---|----------------------------------|--|---|---|--|
| BIRTH NO.   |                                  | 1. NAME OF DECEASED<br>(Type or Print) <i>Anna Freitag</i>   |   | 2. DATE OF DEATH<br><i>July 4/50</i>  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Md.</i> B. COUNTY |   |   |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION<br><i>139 N. Linwood Ave.</i>   |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)<br><i>Balto. 6-01</i>                    |   |   |  |
| C. Length of stay in Baltimore<br>Yrs. Mos. Days  |                                  | D. STREET ADDRESS (If rural, give location)<br><i>139 N. Linwood Ave.</i>  |   |   |  |
| 5. SEX<br><i>Female</i>   | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Widow</i>  | 8. DATE OF BIRTH<br><i>Mar. 26-1870</i> |   | 9. AGE (In years last birthday)<br><i>80</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)<br><i>Balto. Md.</i>                      |  |
| 13. FATHER'S NAME<br><i>Charles A. Schneemann</i>   |                                  | 14. MOTHER'S MAIDEN NAME<br><i>Anna Flathmann</i>  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)   |                                  | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS<br><i>Christopher Guaty 139 N. Linwood Ave.</i>               |  |
| 18. <i>443 X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><br>DUE TO (A) <i>Cerebral Hemorrhage</i><br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B) <i>Hypertensive Cardio-vascular Disease</i><br><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>(C) |                                  | CAUSE OF DEATH   |   | INTERVAL BETWEEN ONSET AND DEATH<br><i>9 weeks</i>                                  |  |
| 19A. DATE OF OPERATION  |                                  | 19B. MAJOR FINDINGS OF OPERATION   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br><i>Home</i>               |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>              |   | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <i>April 28, 1950</i> to <i>July 4, 1950</i> that I last saw the deceased alive on <i>July 3, 1950</i> and that death occurred at <i>8:30 a.m.</i> , from the causes and on the date stated above.   |                                  |  |   |   |  |
| 23A. SIGNATURE<br><i>Francis J. Januszewski</i>   |                                  | 23B. ADDRESS<br><i>540 N. Linwood Ave.</i>   |   | 23C. DATE SIGNED<br><i>7-5-50</i>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |                                  | 24B. DATE<br><i>July 7-50</i>  |   | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Oak Lawn Cemetery</i>                      |  |
| 24D. LOCATION (City, town, or county) (State)<br><i>Balto. Md.</i>  |                                  | 24E. FUNERAL DIRECTOR<br><i>John A. Miller</i>   |   | 24F. ADDRESS<br><i>2334 Jefferson St.</i>   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUL 6-1950</i>   |                                  |  |   |   |  |

MEDICAL CERTIFICATION

937

UNITED STATES OF AMERICA

DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C. 20530

INVESTIGATION OF THE

ACTS OF VIOLENCE

COMMITTED BY THE

BLACK PANTHER PARTY

IN THE CITY OF

ATLANTA, GEORGIA

ON APRIL 4, 1968

AT THE RESIDENCE OF

DR. MARTIN LUTHER KING, JR.

444 CHURCH STREET, N.E.

ATLANTA, GEORGIA 30308

AT 10:00 A.M.

ON APRIL 4, 1968

AT THE RESIDENCE OF

DR. MARTIN LUTHER KING, JR.

444 CHURCH STREET, N.E.

ATLANTA, GEORGIA 30308

AT 10:00 A.M.

ON APRIL 4, 1968

AT THE RESIDENCE OF

DR. MARTIN LUTHER KING, JR.

444 CHURCH STREET, N.E.

ATLANTA, GEORGIA 30308

AT 10:00 A.M.

ON APRIL 4, 1968

AT THE RESIDENCE OF

DR. MARTIN LUTHER KING, JR.

300  
5927BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5927  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Frederick W. Scott

2. DATE  
OF  
DEATH

July-2-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Cold Spring Convalescent Home

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

Life

5. SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

W

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 5-01

D. STREET ADDRESS (If rural, give location)

507-N. Central Ave.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

yes.

13. FATHER'S NAME

Howard Washington

14. MOTHER'S MAIDEN NAME

Cordelia Francis Scott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

unk

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
Georgette Etta Robinson Jefferson

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia, terminal 2 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arthritis, lower extremities 1 yr

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 2, 1950, to July 2, 1950, that I last saw the deceased alive on July 2, 1950, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

23A. SIGNATURE

H. P. Johnson M. D.

23B. ADDRESS

403 N. 2nd St. Bg 7.5:50

23C. DATE SIGNED

7.5:50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

July 7-50

24C. NAME OF CEMETERY OR CREMATORY

Mt Zion

24D. LOCATION (City, town, or county) (State)

Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Holland Funeral Home 1631 - Bayview



Handwritten notes and markings, including a large 'X' and various illegible scribbles.

M-460

50

5928

BALTIMORE CITY HEALTH DEPARTMENT

50

5928

## CERTIFICATE OF DEATH

Registered No.

|   |                           |  |                              |
|---|---------------------------|--|------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print)  |                           | 2. DATE OF DEATH   |                              |
| Rose Miller   |                           | 7-4-50   |                              |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland Balto.  |                           | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Md B. COUNTY |                              |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br>2053 Gough Street  |                           | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Balto., Md. 2-01               |                              |
| 6. LENGTH OF STAY IN BALTIMORE<br>Life  |                           | D. STREET ADDRESS (If rural, give location)<br>2053 Gough Street   |                              |
| 7. SEX<br>Female  | 8. COLOR OR RACE<br>White | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>widowed   | 10. DATE OF BIRTH<br>7-21-84 |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife |                           | 12. AGE (In years last birthday)<br>65   |                              |
| 13. FATHER'S NAME<br>John Semrad  |                           | 14. BIRTHPLACE (State or foreign country)<br>Baltimore   |                              |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)                     |                           | 16. CITIZEN OF WHAT COUNTRY?<br>USA  |                              |
| 17. SOCIAL SECURITY NO.   |                           | 18. MOTHER'S MAIDEN NAME<br>Antonia ?  |                              |
| 19. INFORMANT<br>Michael R. Miller  |                           | 20. ADDRESS<br>2053 Gough Street   |                              |

|  |  |                |  |                                  |  |
|--|--|----------------|--|----------------------------------|--|
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) |  | CAUSE OF DEATH |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| (A) Carcinoma of Stomach   |  | DUE TO         |  |                                  |  |
| ANTECEDENT CAUSES  |  | (B)            |  |                                  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  | DUE TO         |  |                                  |  |
| (C)  |  |                |  |                                  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |                |  |                                  |  |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 19A. DATE OF OPERATION 0  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  | 21B. PLACE OF INJURY (e.g., to or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from June 10, 1950, to July 4, 1950, that I last saw the deceased alive on July 2, 1950, and that death occurred at 7 9 m., from the causes and on the date stated above. |  |   |  |  |  |
| 23A. SIGNATURE<br>C. R. Semrad  |  | 23B. ADDRESS<br>2053 Gough Street   |  | 23C. DATE SIGNED   |  |

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial |  | 24B. DATE<br>7-7-50                     |  | 24C. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer |  | 24D. LOCATION (City, town, or county) (State)<br>Balto., Md. |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br>JUL 6 - 1950    |  | REGISTRAR'S SIGNATURE<br>R. W. Williams |  | 25. FUNERAL DIRECTOR<br>Lilly & Zeiler Inc          |  | ADDRESS<br>403 S. Wolfe Street                               |  |

46B

1-1-50

Boat Hill

Radio

Hall, W.

1000 10th Ave

1000 10th Street

11th

35

1-1-50

11th

11th

11th

11th

11th

11th

11th

11th

11th 10th Street

11th 10th Street

Hall, W.

10th 10th Street

11th 10th Street

11th 10th Street

11th 10th Street

11th 10th Street

11th 10th Street

455

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5920  
Registered No.BIRTH NO. 50 5920  
4-495831. NAME OF DECEASED  
(Type or Print)

Paul L. Kilman

2. DATE  
OF  
DEATH

July 4, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Balto.

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

3-02

D. STREET ADDRESS (If rural, give location)

1109 E. Baltimore St.

Length of stay in Baltimore

life

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Infant

8. DATE OF BIRTH

6-12-46

9. AGE (In years  
last birthday)

4

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY?  
USA

13. FATHER'S NAME

Richard Kilmon

14. MOTHER'S MAIDEN NAME

Lillian Kapple

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mrs Lillian Kilmon, 1109 E. Balto. Street

ADDRESS

18. E 9-29-8

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Drowning

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., In or  
about home, farm, factory, street, office bldg., etc.)

Harbor

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Pier #6 Pratt St.

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

July 4, 1950 abt. 9:55 p.m.

21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
WORK AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell off pier into harbor

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

July 5, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7-8-50

24C. NAME OF CEMETERY OR CREMATORY

Schwartz's

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Lilly &amp; Zeiler, Inc 403 S. Wolfe Street

V. 5116-1950

N-990X

183 ✓

MEDICAL CERTIFICATION



|   |                              |  |   |                                |  |
|---|------------------------------|--|---|--------------------------------|--|
| BIRTH NO. <u>49-14047</u>   |                              | 1. NAME OF DECEASED<br>(Type or Print) <u>Irene S. Sieg</u>      |   | 2. DATE OF DEATH <u>7-5-50</u> |  |
| 3. PLACE OF DEATH:<br>A. <u>Baltimore City, Maryland</u> <u>Baltimore</u>                   |                              |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>Md</u> B. COUNTY _____ |                                |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><u>Sinai Hospital</u>                            |                              |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><u>Balto., Md.</u> <u>15-02</u>             |                                |  |
| C. Length of stay in Baltimore <u>life</u>  |                              |  | D. STREET ADDRESS (If rural, give location)<br><u>1807 N. Monroe Street</u>   |                                |  |
| 5. SEX<br><u>F</u>  | 6. COLOR OR RACE<br><u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Infant</u> | 8. DATE OF BIRTH<br><u>7-10-49</u>  |                                | 9. AGE (In years, last birthday)<br><u>11</u> <u>5</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |                              | 10B. KIND OF BUSINESS OR INDUSTRY                                | 11. BIRTHPLACE (State or foreign country)<br><u>Balto. Md.</u>  |                                | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>             |
| 13. FATHER'S NAME<br><u>Frank Sieg</u>  |                              |  | 14. MOTHER'S MAIDEN NAME<br><u>Irene Hartlove</u>   |                                |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)                           |                              | 16. SOCIAL SECURITY NO.  | 17. INFORMANT ADDRESS<br><u>Frank Sieg 1807 N. Monroe Street</u>  |                                |  |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 18. <u>158 X</u>   |  | CAUSE OF DEATH  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   |  | (A) <u>Retroperitoneal malignancy</u><br>DUE TO <u>(SARCOMA)</u>  |  |   |  |
| ANTECEDENT CAUSES  |  | (B) <u>with metastases</u><br>DUE TO _____  |  |   |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  | (C) _____   |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |   |  |   |  |
| 19A. DATE OF OPERATION <u>0</u>  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>INJURY  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <u>6 - 17</u> , 19 <u>50</u> , to <u>7 - 5</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>7-5</u> , 19 <u>50</u> , and that death occurred at <u>6:25</u> Am., from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE<br><u>Isidore B. Landau</u>   |  | 23B. ADDRESS<br><u>Sinai Hosp. Bal</u>  |  | 23C. DATE SIGNED<br><u>7-5-50</u>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 24B. DATE<br><u>7-8-50</u>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Baltimore</u>                              |  |
|  |  |   |  | 24D. LOCATION (City, town, or county) (State)<br><u>Baltimore, Md.</u>              |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><u>Jul 6 - 1950</u>  |  | REGISTRAR'S SIGNATURE<br><u>Wilmington Williams, Md</u>   |  | 25. FUNERAL DIRECTOR ADDRESS<br><u>Lilly &amp; Zeiler, Inc, 403 S. Wolfe Street</u> |  |



UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

1910

June 1, 1910

Mr.

Mr. J. H. ...

El Paso, Tex.

San Antonio, Tex.

1001 N. ... Street

...

10

1-10-10

...

...

...

Frank ... 1001 N. ... Street

1001 N. ... Street

560  
50 5931BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5931  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mildred A. Gummer

2. DATE  
OF

DEATH July 5th, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

3213 E. Fairmont Ave.

C. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

217 So. Robinson St.

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Oct. 19th, 1901

9. AGE (In years,  
last birthday)

48

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Edward V. Fryer

14. MOTHER'S MAIDEN NAME

Adaline Guthrie

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

nn

17. INFORMANT

ADDRESS

Mrs. Adaline Fryer 639 S. Curley St

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) .....

DUE TO

Coronary thrombosis

1 hour

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) .....

DUE TO

Hypertensive cardiovascular  
disease

2 yrs.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) .....

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐  
WORKNOT WHILE ☐  
AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-21, 1945, to 7-5, 1950, that I last saw the  
deceased alive on 7-5, 1950, and that death occurred at 10:25 A.M., from the causes and on the date stated above.

23A. SIGNATURE

John J. Gould

M. D.

23B. ADDRESS

1421 East Ave

23C. DATE SIGNED

7-5-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

7-8-1950

Holy Redeemer

Baltimore Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

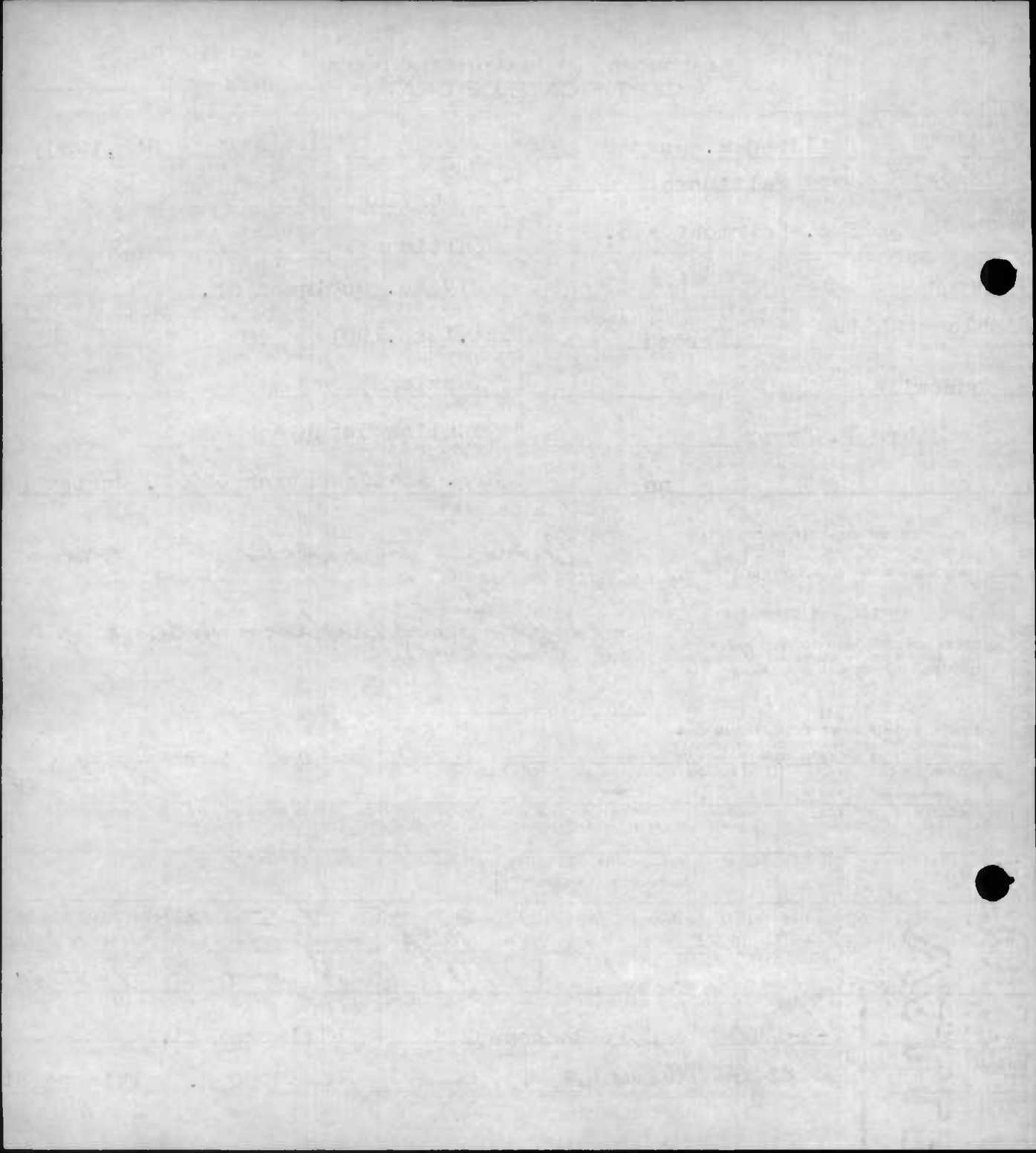
REGISTRAR'S SIGNATURE

Winnington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

John T. Ingram 3000 E. Baltimore St



256

50 5932

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5932  
Registered No.

|  |                  |   |                  |  |                              |
|--|------------------|---|------------------|--|------------------------------|
| BIRTH NO.  |                  | 1. NAME OF DECEASED<br>(Type or Print)  |                  | 2. DATE OF DEATH   |                              |
|  |                  | ISAAC P. WISNER   |                  | July 4, 1950.  |                              |
| 3. PLACE OF DEATH:   |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                           |                  |  |                              |
| A. Baltimore City, Maryland  |                  | A. STATE  |                  | Md.  |                              |
| B. FULL NAME OF HOSPITAL OR INSTITUTION  |                  | C. CITY OR TOWN   |                  | Baltimore  |                              |
| (If not in hospital or institution, give street address or location)   |                  | (If outside corporate limits, write RURAL and give township)  |                  | 26-09  |                              |
| C. Length of stay in Baltimore   |                  | D. STREET ADDRESS (If rural, give location)   |                  | 919 S. Conkling St.  |                              |
| About 13   |                  |   |                  |  |                              |
| Yrs. Mos. Days   |                  |   |                  |  |                              |
| 5. SEX   | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)   | 8. DATE OF BIRTH | 9. AGE (In years last birthday)  | 10. Under 1 Year Months Days |
| Male   | White            | Widowed   | December 5, 1869 | 80   | Hours Min.                   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                  | 10B. KIND OF BUSINESS OR INDUSTRY   |                  | 11. BIRTHPLACE (State or foreign country)                                |                              |
| Retired  |                  | Machinist   |                  | Lancaster, Pa.   |                              |
| 13. FATHER'S NAME  |                  | 14. MOTHER'S MAIDEN NAME  |                  | 12. CITIZEN OF WHAT COUNTRY?   |                              |
| Joseph Wisner  |                  | Mary Reikerindig  |                  | U.S.A.   |                              |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)  |                  | 16. SOCIAL SECURITY NO.   |                  | 17. INFORMANT  |                              |
| No   |                  | None  |                  | Elmer Wisner   |                              |
| 18. 4 yrs. 1   |                  | CAUSE OF DEATH  |                  | ADDRESS  |                              |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |                  | (A) Chv. Myocarditis  |                  | 919 S. Conkling St.  |                              |
| (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  |                  | DUE TO  |                  | INTERVAL BETWEEN ONSET AND DEATH   |                              |
| ANTECEDENT CAUSES  |                  | (B)   |                  | years?   |                              |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |                  | DUE TO  |                  |  |                              |
| (C)  |                  |   |                  |  |                              |
| II   |                  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                  |  |                              |
| 19A. DATE OF OPERATION   |                  | 19B. MAJOR FINDINGS OF OPERATION  |                  | 20. AUTOPSY?   |                              |
| 0  |                  |   |                  | YES <input type="checkbox"/> NO <input type="checkbox"/>                 |                              |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                       |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                              |
|  |                  |   |                  |  |                              |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   |                  | 21E. INJURY OCCURRED  |                  | 21F. HOW DID INJURY OCCUR?   |                              |
|  |                  | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                               |                  |  |                              |
| 22. I hereby certify that I attended the deceased from Jan 5, 1948 to July 4, 1950, that I last saw the deceased alive on July 2, 1950, and that death occurred at 9:30 P.M. from the causes and on the date stated above. |                  |   |                  |  |                              |
| 23A. SIGNATURE   |                  | 23B. ADDRESS  |                  | 23C. DATE SIGNED   |                              |
| N. J. Davidow  |                  | 3218 Eastern ave  |                  | 7-6-50   |                              |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)  |                  | 24B. DATE   |                  | 24C. NAME OF CEMETERY OR CREMATORY                                       |                              |
| Burial   |                  | July 7, 1950  |                  | Greenmount Cemetery  |                              |
|  |                  |   |                  | York, Pa.  |                              |
| DATE RECEIVED BY LOCAL REGISTRAR   |                  | REGISTRAR'S SIGNATURE   |                  | 25. FUNERAL DIRECTOR   |                              |
| JUL 6 - 1950   |                  | Wm. J. Williams, M.D.   |                  | Charles S. Zeiler  |                              |
| VS 150   |                  |   |                  | 901 S. Conkling St.  |                              |

937

*[Faint, illegible text, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher.]*

| B-240<br>50 5933  |                           | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH   |                                   | 50 5933<br>Registered No. _____   |   |
|---|---------------------------|--|-----------------------------------|---|---|
| BIRTH NO.   |                           | 1. NAME OF DECEASED<br>(Type or Print) MARIA F. BOSWELL  |                                   | 2. DATE OF DEATH<br>July 5, 1950  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                           | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Md.<br>B. COUNTY |                                   |   |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION 4011 Kathland Ave.  |                           | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore                          |                                   | 15-10   |   |
| C. Length of stay in Baltimore  |                           | D. STREET ADDRESS (If rural, give location)<br>4011 Kathland Ave.  |                                   |   |   |
| 5. SEX<br>female  | 6. COLOR OR RACE<br>white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>single  | B. DATE OF BIRTH<br>Feb. 14, 1870 | 9. AGE (in years last birthday)<br>80   | If Under 1 Year<br>Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Bookkeeper (rtd)   |                           | 10B. KIND OF BUSINESS OR INDUSTRY<br>Alma Mft. Co.   |                                   | 11. BIRTHPLACE (State or foreign country)<br>Maryland                               |   |
| 12. CITIZEN OF WHAT COUNTRY?  |                           | 13. FATHER'S NAME<br>Fielder Bowie Boswell   |                                   | 14. MOTHER'S MAIDEN NAME<br>Lucy Gantt  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(If yes, give war or dates of service)<br>no  |                           | 16. SOCIAL SECURITY NO.  |                                   | 17. INFORMANT ADDRESS<br>Mr. Ingle Boswell - 4011 Kathland Ave.                     |   |
| 18. 422.1<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>DUE TO (A) <i>Cardiac Deafficiency</i><br>ANTECEDENT CAUSES<br>DUE TO (B) <i>Generalized Arteriosclerosis</i><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO (C)<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                           | CAUSE OF DEATH   |                                   | INTERVAL BETWEEN ONSET AND DEATH  |   |
| 19A. DATE OF OPERATION<br>0   |                           | 19B. MAJOR FINDINGS OF OPERATION   |                                   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |                           | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                          |                                   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |   |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>OF INJURY  |                           | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>          |                                   | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I hereby certify that I attended the deceased from June, 1950, to July 5, 1950, that I last saw the deceased alive on July 3, 1950, and that death occurred at 4 A. M., from the causes and on the date stated above.   |                           |  |                                   |   |   |
| 23A. SIGNATURE<br><i>Frederick Brown</i>  |                           | 23B. ADDRESS<br>M. D. <i>100 E. North Ave.</i>   |                                   | 23C. DATE SIGNED<br>7/6/50  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                           | 24B. DATE<br>7/7/50  |                                   | 24C. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cem.                              |   |
| 24D. LOCATION (City, town, or county) (State)<br>Balto., Md.  |                           | 24E. FUNERAL DIRECTOR<br><i>Thos. J. Fickner &amp; Son</i>   |                                   | 24F. ADDRESS<br><i>Balto., Md.</i>  |   |
| DATE RECEIVED BY LOCAL REGISTRAR  |                           | REGISTRAR'S SIGNATURE<br><i>Wm. J. Williams, M.D.</i>  |                                   | 25. FUNERAL DIRECTOR<br><i>Thos. J. Fickner &amp; Son</i>                           |   |

JUL 6-1950



James M. Smith  
Cotton Supply

July 2 20  
June 20  
July 2 20

520  
50 5934BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5934  
Registered No.

|   |                                  |   |  |   |   |
|---|----------------------------------|---|--|---|---|
| BIRTH NO.   |                                  | 1. NAME OF DECEASED<br>(Type or Print) <b>Paul Clifton King</b>   |  | 2. DATE OF DEATH<br><b>July 3/50</b>                                    |   |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>  |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b><br>B. COUNTY                                 |  |   |   |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>1003 Walnut Ave.</b>  |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 28-04</b>  |  |   |   |
| 6. Length of stay in Baltimore<br><b>Life</b>   |                                  | D. STREET ADDRESS (If rural, give location)<br><b>1003 Walnut Ave.</b>  |  |   |   |
| 7. SEX<br><b>Male</b>   | 8. COLOR OR RACE<br><b>White</b> | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>   | 10. DATE OF BIRTH<br><b>March 30, 1877</b> | 11. AGE (in years last birthday)<br><b>73</b>                           | 12. If Under 1 Year Months: Days<br>If Under 24 Hours Hours: Min. |
| 13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clothing Clerk</b>   |                                  | 14. KIND OF BUSINESS OR INDUSTRY<br><b>Daniel Miller Co.</b>  |  | 15. BIRTHPLACE (State or foreign country)<br><b>Md.</b>                 |   |
| 16. CITIZEN OF WHAT COUNTRY?  |                                  | 17. FATHER'S NAME<br><b>King</b>  |  | 18. MOTHER'S MAIDEN NAME<br><b>Unknown</b>                              |   |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)  |                                  | 20. SOCIAL SECURITY NO.   |  | 21. INFORMANT ADDRESS<br><b>Mrs. Lila King, 1003 Walnut Ave.</b>        |   |
| 22. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cerebral Thrombosis</b>  |                                  | 23. CAUSE OF DEATH<br>(A) <b>Cerebral Thrombosis</b><br>DUE TO<br>(B) <b>Marked generalized arteriosclerotic cardiovascular disease.</b><br>DUE TO<br>(C) |  | 24. INTERVAL BETWEEN ONSET AND DEATH                                    |   |
| 25. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>Chronic myocarditis</b> |                                  | 26. DATE OF OPERATION<br><b>0</b>   |  | 27. MAJOR FINDINGS OF OPERATION   |   |
| 28. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                  | 29. DATE OF OPERATION<br><b>0</b>   |  | 30. MAJOR FINDINGS OF OPERATION   |   |
| 31. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                                  | 32. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 33. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 34. TIME (Month) (Day) (Year) (Hour) INJURY   |                                  | 35. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 36. HOW DID INJURY OCCUR?   |   |
| 37. I hereby certify that I attended the deceased from <b>28 June</b> , 19 <b>50</b> , to <b>3 July</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>3 July</b> , 19 <b>50</b> , and that death occurred at <b>3:50 P.m.</b> , from the causes and on the date stated above. |                                  |   |  |   |   |
| 38. SIGNATURE<br><b>Emil N. Henning Jr.</b>   |                                  | 39. ADDRESS<br><b>601 Winans Way</b>  |  | 40. DATE SIGNED<br><b>5 July 50</b>                                     |   |
| 41. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 42. DATE<br><b>July 6/50</b>  |  | 43. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Pk.</b>                |   |
| 44. LOCATION (City, town, or county) (State)<br><b>Woodlawn, Md.</b>  |                                  | 45. DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 6 - 1950</b>   |  | 46. REGISTRAR'S SIGNATURE<br><b>William H. Williams</b>                 |   |
| 47. FUNERAL DIRECTOR<br><b>Harry H. Lintz</b>   |                                  | 48. ADDRESS<br><b>4101 Edmondson Ave.</b>   |  | 49. VS 150  |   |

3904G

93D

WATERLEY  
CONCRETE  
BOARDS  
100 N. 1st St.  
St. Paul, Minn.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 536<br>50 5935  |  | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH  |  | 50 5935<br>Registered No.   |  |
| BIRTH NO.   |  |   |  |   |  |
| 1. NAME OF DECEASED<br>(Type or Print)  |  | Helen V. Snider   |  | 2. DATE OF DEATH<br>July 4, 1950  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE<br>Maryland<br>B. COUNTY<br>Linthicum |  |   |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>St Agnes Hospital  |  | C. CITY OR TOWN<br>Linthicum  |  | D. STREET ADDRESS (If rural, give location)<br>5200<br>210 W. Maple Road                                |  |
| 5. SEX<br>F.  |  | 6. COLOR OR RACE<br>W   |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Married  |  |
| 8. DATE OF BIRTH<br>10-30   |  | 9. AGE (In years last birthday)<br>56.  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife |  |
| 11. BIRTHPLACE (State or foreign country)<br>New York   |  | 12. CITIZEN OF WHAT COUNTRY?  |  | 13. FATHER'S NAME<br>John F. O'Neill  |  |
| 14. MOTHER'S MAIDEN NAME<br>Mary Jane Elliott   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, oo or uoboww)<br>No  |  | 16. SOCIAL SECURITY NO.<br>-  |  |
| 17. INFORMANT<br>Hospital records   |  | ADDRESS   |  |   |  |
| 18. 193X<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br>(A) Brain Tumor - posterior third ventricle, malignant<br>DUE TO<br>(B)<br>DUE TO<br>(C) |  | INTERVAL BETWEEN ONSET AND DEATH<br>8 weeks over  |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>Overwhelming Toxemia   |  |   |  |   |  |
| 19A. DATE OF OPERATION<br>6-30-50   |  | 19B. MAJOR FINDINGS OF OPERATION<br>Inoperable Brain Tumor  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                               |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from 6-22, 1950, to 7-4, 1950, that I last saw the deceased alive on 7-4, 1950, and that death occurred at 3:38 p.m., from the causes and on the date stated above.   |  |   |  |   |  |
| 23A. SIGNATURE<br>Stephen K. Pashonis   |  | 23B. ADDRESS<br>St. Agnes Hospital  |  | 23C. DATE SIGNED<br>7-4-50  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 24B. DATE<br>July 7/50  |  | 24C. NAME OF CEMETERY OR CREMATORY<br>Baltimore National  |  |
| 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Md.   |  | 24E. FUNERAL DIRECTOR<br>Harry H. Witzke  |  | 24F. ADDRESS<br>101 Edmondson Ave.  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br>JUL 6 - 1950  |  | REGISTRAR'S SIGNATURE<br>William W. Williams  |  |   |  |

MEDICAL CERTIFICATION

54B

Letter in document file 50-5935-7/27/50.

263  
50 5936BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5936

Registered No.

BIRTH NO.

|   |                             |  |   |  |  |
|---|-----------------------------|--|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Scherer</i><br>GLORIA A RICHARDSON                                    |                             |  | 2. DATE OF DEATH<br>July 3, 1950  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                             |  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE<br>Maryland<br>C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore<br>D. STREET ADDRESS (If rural, give location)<br>2009 Harlem Avenue |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>Franklin Square Hospital   |                             |  | 16-04   |  |  |
| C. Length of stay in Baltimore<br>Life  |                             |  | Yrs.<br>Mos.<br>Days  |  |  |
| 5. SEX<br>female  | 6. COLOR OR RACE<br>colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>married | B. DATE OF BIRTH<br>1-31-1929   |  | 9. AGE (In years last birthday)<br>21                  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>machine operator |                             |  | 10B. KIND OF BUSINESS OR INDUSTRY<br>Acme Prod Co.  |  | 11. BIRTHPLACE (State or foreign country)<br>Balt: Md. |
| 13. FATHER'S NAME<br>Charles Scherer  |                             |  | 14. MOTHER'S MAIDEN NAME<br>Mabel Curtis  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>no  |                             |  | 16. SOCIAL SECURITY NO.   |  |  |
| 17. INFORMANT<br>Mabel Scherer  |                             |  | ADDRESS<br>2009 Harlem Ave  |  |  |

|  |  |                                  |
|--|--|----------------------------------|
| 18. <i>E981X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>BULLET WOUNDS OF CHEST AND BRAIN<br>DUE TO<br>ANTecedent CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | CAUSE OF DEATH<br>(A) Bullet wounds of chest and brain<br>DUE TO<br>(B)<br>DUE TO<br>(C) | INTERVAL BETWEEN ONSET AND DEATH |
|--|--|----------------------------------|

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 19A. DATE OF OPERATION<br>7-7-50  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br>home   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>2009 Harlem Avenue |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY<br>July 3, 1950 9.30p. m.   |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?<br>Firearms   |  |
| 22. I certify that I took charge of the remains described above, held an <u>autopsy</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> . |  |   |  |  |  |
| 23A. SIGNATURE<br><i>R. F. Fisher</i>   |  | 23B. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> M.D. MEDICAL INVESTIGATOR..... <input type="checkbox"/> |  | 23C. DATE SIGNED<br>July 4, 1950   |  |

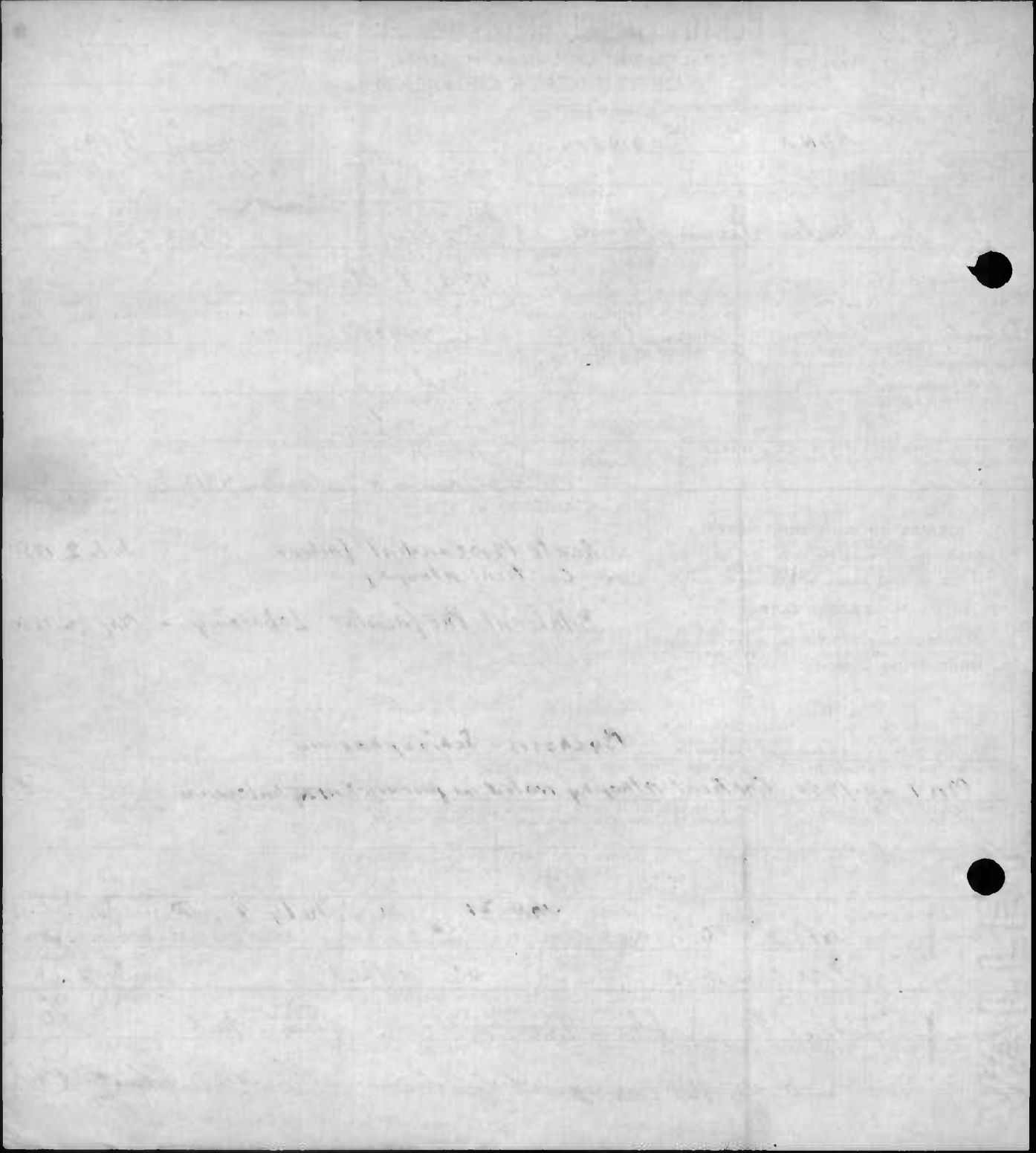
|   |                     |  |   |
|---|---------------------|--|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial | 24B. DATE<br>7/7-50 | 24C. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn   | 24D. LOCATION (City, town, or county) (State)<br>Balt: Md |
| DATE RECEIVED BY LOCAL REGISTRAR<br>JUL 6 - 1950    |                     | REGISTRAR'S SIGNATURE<br>Huntington Williams, M.D. |   |
| 25. FUNERAL DIRECTOR<br>Joseph B. Locke, Jr.        |                     | ADDRESS<br>1304 N. Central Ave                     |   |

853.4 69042 166 ✓





| R-152   |  | 50 5937  |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | 50 5937                                       |  |
|---|--|--|--|--|--|---|--|
| BIRTH NO.   |  |  |  | REGISTERED NO.   |  |   |  |
| 1. NAME OF DECEASED<br>(Type or Print)  |  |  |  | 2. DATE OF DEATH   |  |   |  |
| ANNA R. ROBINSON  |  |  |  | July 4, 1950   |  |   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |  |  |  | 4. USUAL RESIDENCE (Where deceased lived, institution; residence before admission) |  |   |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)  |  |  |  | A. STATE   |  |   |  |
| Ashburton Nursing Home  |  |  |  | Md.  |  |   |  |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  |  |  |  | B. COUNTY  |  |   |  |
| Balto.  |  |  |  | 27-15  |  |   |  |
| D. STREET ADDRESS (If rural, give location)   |  |  |  | 4312 Falls Rd.   |  |   |  |
| E. Length of stay in Baltimore  |  |  |  | Yrs. Mos. Days   |  |   |  |
| 5. SEX  |  | 6. COLOR OR RACE   |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)                                    |  | 8. DATE OF BIRTH                              |  |
| Female  |  | White  |  | Married  |  | June 4, 1909                                  |  |
| 9. AGE (In year - last birthday)  |  | 10. UNDER 1 YEAR   |  | 11. UNDER 24 HOURS   |  | 12. CITIZEN OF WHAT COUNTRY?                  |  |
| 41  |  | Months: Days: Hours: Min.  |  |  |  |   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |  |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| Housewife   |  |  |  | -  |  |   |  |
| 13. FATHER'S NAME   |  |  |  | 14. MOTHER'S MAIDEN NAME   |  |   |  |
| ? John A. A. Miller   |  |  |  | Jennie Heindel   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)  |  |  |  | 16. SOCIAL SECURITY NO.  |  |   |  |
| -   |  |  |  | -  |  |   |  |
| 17. INFORMANT   |  |  |  | ADDRESS  |  |   |  |
| Benjamin H. Robinson  |  |  |  | 4312 Falls Rd.   |  |   |  |
| 18. 355 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                       |  |  |  | CAUSE OF DEATH   |  |   |  |
| ANTECEDENT CAUSES   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  |  |  | (A) Acute Myocardial failure   |  |   |  |
|   |  |  |  | DUE TO Cortical Atrophy  |  |   |  |
|   |  |  |  | (B) Bilateral Prefrontal Lobotomy -  |  |   |  |
|   |  |  |  | DUE TO May 26, 1950  |  |   |  |
|   |  |  |  | (C) Psychosis - Schizophrenia  |  |   |  |
| 19A. DATE OF OPERATION  |  |  |  | 19B. MAJOR FINDINGS OF OPERATION   |  |   |  |
| May 26, 1950  |  |  |  | Cortical Atrophy noted on pneumoencephalogram                                      |  |   |  |
| 20. AUTOPSY?  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                |  |   |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)           |  |   |  |
|   |  |  |  |  |  |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour)   |  | 21E. INJURY OCCURRED   |  | 21F. HOW DID INJURY OCCUR?   |  |   |  |
| INJURY  |  | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>        |  |  |  |   |  |
| 22. I hereby certify that I attended the deceased from Jan 21, 1950, to July 4, 1950, that I last saw the deceased alive on July 2, 1950, and that death occurred at 5:20 A.M., from the causes and on the date stated above. |  |  |  |  |  |   |  |
| 23A. SIGNATURE  |  |  |  | 23B. ADDRESS   |  | 23C. DATE SIGNED                              |  |
| Ben Robinson M.D.   |  |  |  | 1031 St Paul St  |  | July 7, 1950                                  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   |  | 24B. DATE  |  | 24C. NAME OF CEMETERY OR CREMATORY   |  | 24D. LOCATION (City, town, or county) (State) |  |
| Burial  |  | 7/7/50   |  | St. Paul's Church  |  | Baltimore, Md.                                |  |
| DATE RECEIVED BY LOCAL REGISTRAR  |  | REGISTRAR'S SIGNATURE  |  | 25. FUNERAL DIRECTOR   |  | ADDRESS                                       |  |
| JUL 6 - 1950  |  | William H. Williams, M.D.  |  | Paul E. Chismuth   |  | 3615-12 Chestnut Ave                          |  |
| VS 150 DR Freedom PNEUMOENCEPHALOGRAPHY   |  |  |  |  |  |   |  |



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5938

BIRTH NO. 50-13678

1. NAME OF DECEASED  
(Type or Print)

Baby O' DUNNELL

2. DATE  
OF  
DEATH

7-5-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

St. Agnes Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

Howard

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto. Md.

D. STREET ADDRESS (If rural, give location)

Route 2 Ellicott City Md.

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

7-5-50

9. AGE (In years, last birthday)

If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.

1 45

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John O'Donnell

14. MOTHER'S MAIDEN NAME

Sacredine Sullivan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

John L. O'Donnell Route 2 Ellicott City

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Immaturity

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 7-5 1950, to 7-5 1950, that I last saw the deceased alive on 7-5 1950, and that death occurred at 3:15 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Handwritten signature

23B. ADDRESS

St Agnes Hosp

23C. DATE SIGNED

7-5-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

7/7/50

New Cathedral

Fredrick Rd.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 6 1950

Handwritten signature

Handwritten signature

159

MEDICAL CERTIFICATION

5-2-70

Mr. J. D. [unclear]

Dear Mr. [unclear]

Dear Mr. [unclear]

I am writing to you

I am writing to you

regarding the [unclear]

regarding the [unclear]

which I have [unclear]

which I have [unclear]

and I am [unclear]

and I am [unclear]

Very truly yours,

Very truly yours,

[unclear]

[unclear]

[unclear]

[unclear]

[unclear]

[unclear]

[unclear]

[unclear]

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5939  
Registered No.

BIRTH NO. 5939

|   |                        |   |   |                                       |                               |
|---|------------------------|---|---|---------------------------------------|-------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) ALOYSIOUS F HOH  |                        |   | 2. DATE OF DEATH July 4, 1950   |                                       |                               |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland Balto   |                        |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland<br>B. COUNTY   |                                       |                               |
| B. FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital   |                        |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 26-02   |                                       |                               |
| C. Length of stay in Baltimore Life Yrs. Mos. Days  |                        |   | D. STREET ADDRESS (If rural, give location)<br>2400 Bowleys Lane  |                                       |                               |
| 5. SEX Male   | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH Oct 3-1888   | 9. AGE (In years last birthday) 66 61 | 10. Under 1 Year Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter   |                        |   | 11. BIRTHPLACE (State or foreign country) Balto   |                                       | 12. CITIZEN OF WHAT COUNTRY?  |
| 13. FATHER'S NAME John Hoh  |                        |   | 14. MOTHER'S MAIDEN NAME ?  |                                       |                               |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |                        |   | 16. SOCIAL SECURITY NO. 213-67-9927   |                                       |                               |
| 17. INFORMANT Mrs. Johnson  |                        |   | ADDRESS 2400 Bowleys Lane   |                                       |                               |
| 18. E916.3 I CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>2nd and 3rd degree burns of 95% of body<br>INTERVAL BETWEEN ONSET AND DEATH   |                        |   |   |                                       |                               |
| II ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO<br>(B)<br>(C)   |                        |   |   |                                       |                               |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                        |   |   |                                       |                               |
| 19A. DATE OF OPERATION  |                        |   | 19B. MAJOR FINDINGS OF OPERATION  |                                       |                               |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                        |   |   |                                       |                               |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                        |   | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Industrial place  |                                       |                               |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Bethlehem Steel Co., Sparrows Point  |                        |   |   |                                       |                               |
| 21D. TIME (Month) (Day) (Year) (Hour) July 4, 1950 10:15 A. m.  |                        |   | 21E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                                       |                               |
| 21F. HOW DID INJURY OCCUR? Explosion of oil in pipe line  |                        |   |   |                                       |                               |
| 22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |                        |   |   |                                       |                               |
| 23A. SIGNATURE R. S. Fisher M.D.  |                        |   | 23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/> |                                       |                               |
| 23C. DATE SIGNED July 5, 1950   |                        |   |   |                                       |                               |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial  |                        |   | 24B. DATE July 10-50  |                                       |                               |
| 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer  |                        |   | 24D. LOCATION (City, town, or county) Balto Md  |                                       |                               |
| DATE RECEIVED BY LOCAL REGISTRAR JUL 6-1950   |                        |   | REGISTRAR'S SIGNATURE William H. Miller   |                                       |                               |
| 25. FUNERAL DIRECTOR J. J. Herr + Son   |                        |   | ADDRESS 181 3001 Kentucky Ave   |                                       |                               |

MEDICAL CERTIFICATION



Anna C. Hobbs  
June 16 - 47

CEDARVILLE OH. DEVIN

WINDMILL COT. N. VINEYARD

**Med. Exam Case. Released to Hosp.**  
**BALTIMORE CITY HEALTH DEPARTMENT**  
**CERTIFICATE OF DEATH** 50 5940  
 Registered No. X

**Med. Exam Room**  
 BIRTH NO. \_\_\_\_\_

|   |  |  |  |
|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>William Pearce</b>                |  | 2. DATE OF DEATH <b>July 5, 1950</b>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>Acch Room</b>          |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>md</b> B. COUNTY <b>Baltimore</b> |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b>       |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Bochesville 5300</b>                                |  |
| D. STREET ADDRESS (If rural, give location)<br><b>Sherwood Road</b>         |  |  |  |
| 5. SEX <b>Male</b>  |  | 6. COLOR OR RACE <b>White</b>  |  |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>               |  | 8. DATE OF BIRTH <b>11-15-1872</b>   |  |
| 9. AGE (In years last birthday) <b>77</b>                                   |  | 10. AGE (In years last birthday) <b>77</b>   |  |
| 11. BIRTHPLACE (State or foreign country) <b>Balto Co. Md.</b>              |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |
| 13. FATHER'S NAME <b>Caleb Pearce</b>                                       |  | 14. MOTHER'S MAIDEN NAME <b>Sarah Ann Gill</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> |  | 16. SOCIAL SECURITY NO. _____  |  |
| 17. INFORMANT <b>JOHNS HOPKINS HOSPITAL</b>                                 |  | ADDRESS _____  |  |

18. **561.5** 1  
 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
 (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
**ASPIRATION PNEUMONIA**  
 DUE TO \_\_\_\_\_

19. **561.5** 2  
 ANTECEDENT CAUSES  
 DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  
**INTESTINAL OBSTRUCTION**  
 DUE TO \_\_\_\_\_

20. **561.5** 3  
 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  
**STRANGULATED HERNIA**  
 DUE TO \_\_\_\_\_

21. **561.5** 4  
 INTERVAL BETWEEN ONSET AND DEATH  
**2 mos**  
**3 DAYS**  
**3 DAYS**

22. I hereby certify that I attended the deceased from **7-5-1950** to **7-5-1950**, that I last saw the deceased alive on **7-5-1950** and that death occurred at **2:30 p.m.**, from the causes and on the date stated above.

23. SIGNATURE **Arthur R. Nelson** M. D. 23b. ADDRESS **JOHNS HOPKINS HOSPITAL** 23c. DATE SIGNED **7/5/50**

24. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24b. DATE **7-8-50** 24c. NAME OF CEMETERY OR CREMATORY **Gessops Methodist** 24d. LOCATION (City, town, or county) (State) **Sparks, Balto, Md.**

DATE RECEIVED BY LOCAL REGISTRAR **JUL 6 - 1950** REGISTRAR'S SIGNATURE **Wilmington Williams, Md.** 25. FUNERAL DIRECTOR **F. Scott Brooks** ADDRESS **Sparks, Md.**

VS 150  
 To be approved by Med Exam 122a

NOT A MEDICAL EXAMINER'S CASE

*Robert F. Fisher*

M.D.

CHIEF OR ASST. MEDICAL EXAMINER

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5941  
Registered No.

BIRTH NO.

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>John Thomas Flynn</b>  |                                  | 2. DATE OF DEATH <b>July 4, 1950</b>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY |  |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>3900 Park Heights Ave.,</b>  |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore, 15-12</b>                |  |
| 6. LENGTH OF STAY IN BALTIMORE <b>life</b>   |                                  | D. STREET ADDRESS (If rural, give location)<br><b>3900 Park Heights Ave.</b>   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widower</b>  | 8. DATE OF BIRTH<br><b>June 23, 1876</b>     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Vice President</b> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Bank</b>   | 9. AGE (In years last birthday)<br><b>74</b> |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Michael F. Flynn,</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Kane.</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>no</b>                                       |                                  | 16. SOCIAL SECURITY NO.<br><b>217-14-6270</b>  |  |
| 17. INFORMANT<br><b>Mr. John T. Flynn, Jr.</b>   |                                  | ADDRESS<br><b>708 Braeside Rd.</b>   |  |

|   |  |  |
|---|--|--|
| 18. <b>420.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Coronary Thrombosis,</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>30 days</b> |
| (A) DUE TO<br><b>Arteriosclerosis, Generalized.</b>   |  |  |
| (B) DUE TO  |  |  |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Arteriosclerosis, Generalized.</b>   |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |  |

|   |   |   |  |  |  |
|---|---|---|--|--|--|
| 19A. DATE OF OPERATION  |   | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |  |  |  |
| 22. I hereby certify that I attended the deceased from <b>June 1, 1948</b> , to <b>July 4, 1950</b> , that I last saw the deceased alive on <b>July 4, 1950</b> , and that death occurred at <b>3:30 P.m.</b> , from the causes and on the date stated above. |   |   |  |  |  |
| 23A. SIGNATURE<br><b>Charles H. Williams</b>  |   | 23B. ADDRESS<br><b>M. Walkr Av. &amp; Reistwn Rd. Pikesville, Md.</b>               |  | 23C. DATE SIGNED<br><b>7/1/50</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>  | 24B. DATE<br><b>July 7, 1950</b>  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Cathedral</b>                              | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b> |  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 6 - 1950</b>   | REGISTRAR'S SIGNATURE<br><b>Wilmington Williams, M.D.</b>   | 25. FUNERAL DIRECTOR<br><b>Edw. Lemmon</b> ADDRESS<br><b>4611 Park Heights Ave.</b> |  |  |  |

**29071**

**94a**

959-25-7

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5942

Registered No. \_\_\_\_\_

650  
BIRTH NO. 5942

|  |                                  |   |   |  |   |
|--|----------------------------------|---|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>ELIZABETH GILLET CORWIN (MRS CLIFFORD E)</b>   |                                  |   | 2. DATE OF DEATH <b>7/6/50</b>  |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>OHIO</b> B. COUNTY <b>V-32</b> |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>UNION MEMORIAL HOSPITAL</b> |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>MARIETTA</b>                                     |  |   |
| C. Length of stay in Baltimore<br>Yrs. Mos. Days   |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>508 5TH STREET</b>  |  |   |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>WIDOWED</b> | 8. DATE OF BIRTH<br><b>SEPT 6, 1866</b>   |  | 9. AGE (In years last birthday)<br><b>83</b>  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HSWF.</b>                                    |                                  | 10B. KIND OF BUSINESS OR INDUSTRY                                 | 11. BIRTHPLACE (State or foreign country)<br><b>NEW HAMPSHIRE</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |
| 13. FATHER'S NAME<br><b>RODNEY M. STIMSON</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>JULIA SHEPPARD</b>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                       |                                  | 16. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS<br><b>DR. A. H. CORWIN 2903 OVERLAND AVE. BALTO.</b>  |  |   |

|  |   |  |   |
|--|---|--|---|
| <p>18. <b>170X</b></p> <p><b>I</b></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br/>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>metastatic Carcinoma</b></p> <p>DUE TO</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p><b>Carcinoma of the Breast</b></p> <p>DUE TO</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> | <p align="center"><b>CAUSE OF DEATH</b></p> <p>(A) <b>metastatic Carcinoma</b></p> <p>(B) <b>Carcinoma of the Breast</b></p> <p>(C)</p> |  | <p>INTERVAL BETWEEN ONSET AND DEATH</p> |
|  |   |  |   |
|  |   |  |   |

|   |   |  |   |   |  |
|---|---|--|---|---|--|
| 19A. DATE OF OPERATION <b>7-9-50</b>  |   | 19B. MAJOR FINDINGS OF OPERATION   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |   |  |
| 22. I hereby certify that I attended the deceased from <b>1 July 1950</b> , to <b>6 July 1950</b> that I last saw the deceased alive on <b>5 July 1950</b> , and that death occurred at <b>10:50 a.m.</b> , from the causes and on the date stated above. |   |  |   |   |  |
| 23A. SIGNATURE<br><b>Walter J. Buttrick, M.D.</b>   |   | 23B. ADDRESS<br><b>Union Memorial Hospital</b>                           |   | 23C. DATE SIGNED<br><b>6 July 1950</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)   | 24B. DATE<br><b>7-9-50</b>  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Marietta Cem.</b>               | 24D. LOCATION (City, town, or county) (State)<br><b>Marietta Ohio</b> |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 6 - 1950</b>   | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b>   | 25. FUNERAL DIRECTOR<br><b>John J. Wenny Inc</b>                         |   | ADDRESS<br><b>715 Light</b>   |  |

MEDICAL CERTIFICATION



UNITED STATES OF AMERICA

DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C. 20530

MEMORANDUM FOR THE ATTORNEY GENERAL

DATE: 10/10/68

TO: THE ATTORNEY GENERAL

FROM: [REDACTED]

SUBJECT: [REDACTED]

1. [REDACTED]

2. [REDACTED]

3. [REDACTED]

4. [REDACTED]

5. [REDACTED]

6. [REDACTED]

7. [REDACTED]

8. [REDACTED]

9. [REDACTED]

10. [REDACTED]

11. [REDACTED]

12. [REDACTED]

13. [REDACTED]

14. [REDACTED]

15. [REDACTED]

16. [REDACTED]

17. [REDACTED]

18. [REDACTED]

19. [REDACTED]

20. [REDACTED]

21. [REDACTED]

22. [REDACTED]

23. [REDACTED]

24. [REDACTED]

25. [REDACTED]

26. [REDACTED]

27. [REDACTED]

28. [REDACTED]

29. [REDACTED]

30. [REDACTED]

31. [REDACTED]

32. [REDACTED]

33. [REDACTED]

34. [REDACTED]

35. [REDACTED]

36. [REDACTED]

37. [REDACTED]

38. [REDACTED]

39. [REDACTED]

324  
5943BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5943  
Registered No.

|  |                              |  |                                    |
|--|------------------------------|--|------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Mrs MATILDA MITCHELL</b>  |                              | 2. DATE OF DEATH<br><b>7-4-50</b>  |                                    |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                              | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE<br><b>MD.</b><br>B. COUNTY<br><b>BALTIMORE</b> |                                    |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>BON SECOURS HOSPITAL</b>   |                              | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTIMORE</b>   |                                    |
| D. STREET ADDRESS (If rural, give location)<br><b>220 S. AUGUSTA AVE.</b>  |                              | E. LENGTH OF STAY IN BALTIMORE<br>Yrs.<br>Mos.<br>Days   |                                    |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>N</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>M</b>  | 8. DATE OF BIRTH<br><b>10-7-01</b> |
| 9. AGE (In years last birthday)<br><b>42</b>   |                              | 10. Under 1 Year<br>Months: Days   |                                    |
| 11. Under 24 Hours<br>Hours: Min.  |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                    |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>  |                              | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>AT-Home</b>  |                                    |
| 13. FATHER'S NAME<br><b>3rd</b>  |                              | 14. MOTHER'S MAIDEN NAME<br><b>Matilda Kraft</b>   |                                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                              | 16. SOCIAL SECURITY NO.<br><b>3rd</b>  |                                    |
| 17. INFORMANT<br><b>Matilda Mitchell - Sister</b>  |                              | ADDRESS  |                                    |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Aspiration Bronchial Secretion</b><br>DUE TO<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Bronchial Asthma</b><br>DUE TO<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>Occured immediately following Bronchoscopy</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>15 min</b><br><b>14 yrs</b><br>CERTIFICATION APPROVED BY<br><b>RS Fisher M.D.</b><br>CHIEF OR ASST. MEDICAL EXAMINER. |                              |  |                                    |
| 19A. DATE OF OPERATION<br><b>July 4, 1950</b>  |                              | 19B. MAJOR FINDINGS OF OPERATION<br><b>Bronchoscopy</b>  |                                    |
| 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                              |  |                                    |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)<br><b>Accident</b>  |                              | 21B. PLACE OF INJURY (e.g., if or about home, farm, factory, street, office bldg., etc.)<br><b>Hospital</b>                                      |                                    |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>Bon Secours Hospital, Payson &amp; Fayette St</b>   |                              | 21D. TIME (Month) (Day) (Year) (Hour)<br><b>July 4, 1950</b>   |                                    |
| 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                              | 21F. HOW DID INJURY OCCUR?<br><b>Aspiration of bronchial secretion during bronchoscopy</b>   |                                    |
| 22. I hereby certify that I attended the deceased from <b>7-1-1950</b> to <b>7-4, 1950</b> , that I last saw the deceased alive on <b>7-4, 1950</b> , and that death occurred at <b>12:45 Pm.</b> , from the causes and on the date stated above.  |                              |  |                                    |
| 23A. SIGNATURE<br><b>Dr. R. Solomon</b>  |                              | 23B. ADDRESS<br><b>Bon Secours Hospital</b>  |                                    |
| 23C. DATE SIGNED<br><b>7-4-50</b>  |                              |  |                                    |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                              | 24B. DATE<br><b>July 8-50</b>  |                                    |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>Landon Park</b>   |                              | 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b>   |                                    |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 6 - 1950</b>  |                              | REGISTRAR'S SIGNATURE<br><b>Thurston Williams</b>  |                                    |
| VS 150   |                              | 25. FUNERAL DIRECTOR<br><b>W. B. ...</b>   |                                    |
|  |                              | ADDRESS<br><b>1300 E. ...</b>  |                                    |

MEDICAL CERTIFICATION

112

UNITED STATES OF AMERICA  
DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
DATE: [illegible]  
[The remainder of the page contains several paragraphs of extremely faint, illegible text, likely a memorandum or report.]

432  
50 5944

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5944

|  |   |  |  |  |  |
|--|---|--|--|--|--|
| BIRTH NO.  |   | 1. NAME OF DECEASED<br>(Type or Print) <b>WILLIAM FLETCHER</b>   |  | 2. DATE OF DEATH<br><b>7-4-50</b>  |  |
| 3. PLACE OF DEATH:<br>a. Baltimore City, Maryland  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> |  |  |  |
| b. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>WEST BALTIMORE GENERAL HOSP.</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>   |  |  |  |
| c. Length of stay in Baltimore   |   | d. STREET ADDRESS (If rural, give location)<br><b>238 N. Franklin Truss Rd</b>   |  |  |  |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>W</b>  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>MARRIED</b>  |  | 8. DATE OF BIRTH<br><b>Jan. 13, 1903</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Watchman - Balto. City Court House</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 9. AGE (In years, last birthday) <b>47</b><br>If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min. |  |
| 13. FATHER'S NAME<br><b>James P. Fletcher</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Emma E. Smith</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)  |   | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br><b>Mary C. Fletcher - Same</b>  |  |
| 18. <b>470.1</b>   |   | CAUSE OF DEATH   |  |  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  |   | (A) <b>ACUTE ANT. MYOCARDIAL INFARCT</b>   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 hrs.</b>  |  |
| ANTECEDENT CAUSES  |   | (B) <b>CORONARY OCCLUSION</b>  |  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |   | (C)  |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                        |  |
| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)   | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  |  |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21e. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I hereby certify that I attended the deceased from <b>7-4-1950</b> to <b>7-4-1950</b> that I last saw the deceased alive on <b>July 4, 1950</b> and that death occurred at <b>12:40 p.m.</b> , from the causes and on the date stated above. |   |  |  |  |  |
| 23a. SIGNATURE<br><b>Miriam S. Daly</b>  |   | 23b. ADDRESS<br><b>WEST BALTIMORE GEN. HOSP.</b>   |  | 23c. DATE SIGNED<br><b>7-4-50</b>  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>cremation</b>  | 24b. DATE<br><b>July 6, 1950</b>  | 24c. NAME OF CEMETERY OR CREMATORY<br><b>London Crematory</b>  |  | 24d. LOCATION (City, town, or county) (State)<br><b>Balto. Md</b>  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 6-1950</b>  |   | REGISTRAR'S SIGNATURE<br><b>Thurston Williams, M.D.</b>  |  | 25. FUNERAL DIRECTOR ADDRESS<br><b>F. B. Whippert 1300 E. 1st Ave</b>                                      |  |

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MEDICAL CERTIFICATION

337185

NOT A MEDICAL EXAMINER'S CASE

*R. Fisher*

M.D.

CHIEF OR ASST. MEDICAL EXAMINER

140

50 5945

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 5945

|  |  |  |                                  |
|--|--|--|----------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Janice Abell</i>   |  | 2. DATE OF DEATH <i>July 5, 1950</i>   |                                  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>LLH 4 E.</i>  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <i>Ind.</i> B. COUNTY <i>Charles</i> |                                  |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Manbury</i>  |                                  |
| 6. Length of stay in Baltimore   |  | D. STREET ADDRESS (If rural, give location) <i>5800</i>  |                                  |
| 7. SEX <i>Female</i>   | 8. COLOR OR RACE <i>White</i>  | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>  | 10. DATE OF BIRTH <i>6-18-50</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 11. BIRTHPLACE (State or foreign country)  |                                  |
| 10B. KIND OF BUSINESS OR INDUSTRY  |  | 12. CITIZEN OF WHAT COUNTRY?   |                                  |
| 13. FATHER'S NAME <i>Ralph Abell</i>   |  | 14. MOTHER'S MAIDEN NAME <i>Frances Lloyd</i>  |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)  |  | 16. SOCIAL SECURITY NO.  |                                  |
| 17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i>  |  | ADDRESS  |                                  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>754.0</i><br><i>congenital Heart Disease</i><br><i>Petrology of Fallot</i> |  | INTERVAL BETWEEN ONSET AND DEATH   |                                  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  |  |                                  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |  |                                  |
| 19A. DATE OF OPERATION <i>7-5-50</i>   |  | 19B. MAJOR FINDINGS OF OPERATION   |                                  |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |                                  |
| 21A. ACCIDENT WAS UNDER- Lying <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                                  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK | 21F. HOW DID INJURY OCCUR?   |                                  |
| 22. I hereby certify that I attended the deceased from <i>6-27-1950</i> to <i>7-5-1950</i> , that I last saw the deceased alive on <i>7-5-1950</i> , and that death occurred at <i>8:10 P.m.</i> , from the causes and on the date stated above.                                     |  |  |                                  |
| 23A. SIGNATURE <i>Leonard F. Rosenzweig</i> M. D.  |  | 23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>   |                                  |
| 23C. DATE SIGNED <i>6 July 50</i>  |  |  |                                  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>  | 24B. DATE <i>7-5-50</i>  | 24C. NAME OF CEMETERY OR CREMATORY <i>Manbury, Md</i>  |                                  |
| 24D. LOCATION (City, town, or county) (State)  |  |  |                                  |
| DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 6 - 1950</i>   |  | 25. FUNERAL DIRECTOR <i>Hunt &amp; Ryan</i> ADDRESS <i>Waldorf Rd</i>  |                                  |



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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5946  
Registered No. \_\_\_\_\_

263  
50 5946  
BIRTH NO. \_\_\_\_\_

|  |                                  |   |  |  |  |
|--|----------------------------------|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <u>Adam Richardson</u>  |                                  |   | 2. DATE OF DEATH<br><u>7/4/50</u>  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <u>Baltimore, Maryland</u>   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <u>Maryland</u><br>B. COUNTY <u>ANNE ARUNDEL</u> |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><u>South Baltimore General Hospital</u>                                       |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)<br><u>Glen Burnie (Rural)</u>  |  |  |
| C. Length of stay in Baltimore <u>Few Hours</u><br>Yrs. _____<br>Mos. _____<br>Days _____                                |                                  |   | D. STREET ADDRESS (If rural, give location)<br><u>Grain Highway - 4 mi. South Glen Burnie</u>  |  |  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Married</u> | 8. DATE OF BIRTH<br><u>8/27/1882</u>   |  | 9. AGE (In years last birthday)<br><u>67</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Pensioned BRAKEMAN</u> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>B.O. RAILROAD</u>         |  | 11. BIRTHPLACE (State or foreign country)<br><u>KINGSTON, Canada</u> |  |
| 13. FATHER'S NAME<br><u>JONATHAN Richardson</u>  |                                  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S.</u>   |  |  |
| 14. MOTHER'S MAIDEN NAME<br><u>JESSIE MACK</u>   |                                  |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u><br>(If yes, give war or dates of service)                              |  |  |
| 16. SOCIAL SECURITY NO.<br><u>705-05-6170</u>  |                                  |   | 17. INFORMANT<br><u>Mrs. ANA. V. RICHARDSON, P.O. Box 83, GLEN BURNIE, MD.</u>   |  |  |

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|---|--|--|
| 18. <u>581.0</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><u>Cirrhosis, Portal</u><br>DUE TO (A) _____ |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>?</u><br><u>?</u><br><u>7 hrs</u> |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><u>Esophageal Varices</u><br>DUE TO (B) _____   |  |  |
| (C) <u>Hemorrhage from (B)</u>  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 19A. DATE OF OPERATION<br><u>none</u>                 |  | 19B. MAJOR FINDINGS OF OPERATION<br><u>none</u>   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)<br>_____   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br>_____        |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>_____   |  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>INJURY _____ |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?<br>_____   |  |

22. I hereby certify that I attended the deceased from 7/4, 1950 to 7/4, 1950 that I last saw the deceased alive on 7/4, 1950, and that death occurred at 10<sup>10</sup> p.m., from the causes and on the date stated above.

|  |  |                                  |  |  |  |
|--|--|----------------------------------|--|--|--|
| 23A. SIGNATURE<br><u>[Signature]</u>                       |  | 23B. ADDRESS<br><u>SBGH</u>      |  | 23C. DATE SIGNED<br><u>7/5/50</u>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u> |  | 24B. DATE<br><u>July 7, 1950</u> |  | 24C. NAME OF CEMETERY OR CREMATORY<br><u>GLEN HAVEN</u>                  |  |
|  |  |                                  |  | 24D. LOCATION (City, town, or county) (State)<br><u>GLEN BURNIE, MD.</u> |  |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| DATE RECEIVED BY LOCAL REGISTRAR<br><u>JUL 6 - 1950</u> |  | REGISTRAR'S SIGNATURE<br><u>[Signature]</u> |  | 25. FUNERAL DIRECTOR<br><u>[Signature]</u> |  |
|   |  |   |  | ADDRESS<br><u>Glen Burnie, MD.</u>         |  |

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MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5947  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

|  |                              |  |   |  |  |
|--|------------------------------|--|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>LILLIE AGNES JUDIK</b>   |                              |  | 2. DATE OF DEATH <b>JULY 6, 1950</b>  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                              |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY _____ |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>UNION MEMORIAL HOSP</b> |                              |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTIMORE 12-01</b>                            |  |  |
| C. Length of stay in Baltimore<br>Yrs. _____ Mos. _____ Days _____   |                              |  | D. STREET ADDRESS (If rural, give location)<br><b>3906 ST PAUL STREET</b>   |  |  |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>SINGLE</b> | 8. DATE OF BIRTH<br><b>APRIL 1877</b>   |  | 9. AGE (In years last birthday) <b>73</b>  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>NONE</b>         |                              | 10B. KIND OF BUSINESS OR INDUSTRY                                | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |
| 13. FATHER'S NAME<br><b>J. HENRY JUDIK</b>   |                              |  | 14. MOTHER'S MAIDEN NAME<br><b>LILLIE ANNIE LEE BRIGUES</b>   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)  |                              | 16. SOCIAL SECURITY NO.  | 17. INFORMANT ADDRESS <b>3906 ST PAUL, BALTIMORE</b><br><b>MRS MARIE DE PIERRON</b>   |  |  |

|  |  |                                  |
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| 18. <b>450.0 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Uremia</b> | CAUSE OF DEATH                                 | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   | (A) DUE TO                                     |                                  |
|  | (B) DUE TO <b>generalized Arteriosclerosis</b> |                                  |
|  | (C) DUE TO                                     |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |                                  |

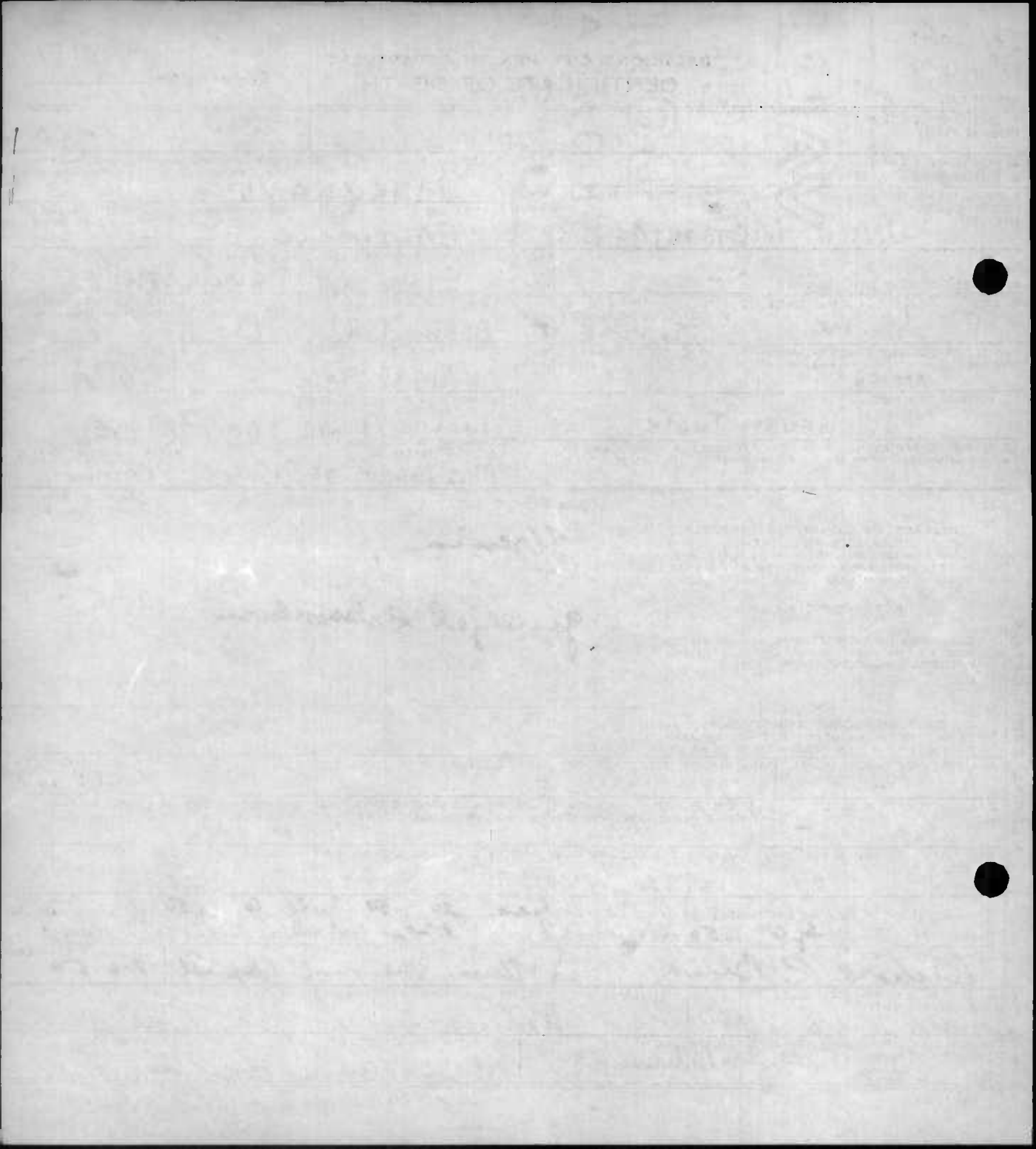
|   |   |   |
|---|---|---|
| 19A. DATE OF OPERATION <b>0</b>                       | 19B. MAJOR FINDINGS OF OPERATION  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <b>-</b>   | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>-</b>        | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>-</b>   |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY <b>-</b> | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? <b>-</b>   |

22. I hereby certify that I attended the deceased from June 10, 1950, to July 6, 1950, that I last saw the deceased alive on July 6, 1950, and that death occurred at 3:20 pm., from the causes and on the date stated above.

23A. SIGNATURE Richard R. Beach M. D. 23B. ADDRESS Union Memorial Hospital 23C. DATE SIGNED 7-6-50

|  |                               |  |  |
|--|-------------------------------|--|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24B. DATE<br><b>July 8/50</b> | 24C. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b> | 24D. LOCATION (City, town, or county) (State)<br><b>Balto Md</b> |
|--|-------------------------------|--|--|

|  |   |   |                                |
|--|---|---|--------------------------------|
| DATE RECEIVED BY<br>LOCAL REGISTRAR<br><b>JUL 6 - 1950</b> | REGISTRAR'S SIGNATURE<br><u>Huntington Williams, M.D.</u> | 25. FUNERAL DIRECTOR<br><u>Henry H. Jenkins</u> | ADDRESS<br><u>4905 York Rd</u> |
|--|---|---|--------------------------------|



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50 5948

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5948  
Registered No.

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>De Lauder, Roscoe Conklin</b>   |                                  | 2. DATE OF DEATH<br><b>July 5, 1950</b>   |  |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>Baltimore</b> |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>U.S. Marine Hospital, Baltimore, Md.</b>   |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore, Md. 27-10</b>                                     |  |
| C. Length of stay in Baltimore<br><b>71 years</b>  |                                  | D. STREET ADDRESS (If rural, give location)<br><b>810 Radnor Ave., Baltimore, Md.</b>   |  |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>married</b>   | 8. DATE OF BIRTH<br><b>August 31, 1879</b>                                   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>steam fitter</b>   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>RAILROAD</b>  | 9. AGE (In years last birthday)<br><b>71</b>                                 |
| 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |
| 13. FATHER'S NAME<br><b>EOGAR DELAUDER</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>MARY CLAGGETT</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>yes</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>SS. 212-16-8761</b>   | 17. INFORMANT<br><b>U.S. Marine Hospital</b>                                 |
| ADDRESS<br><b>SPANISH AMERICAN</b>   |                                  | ADDRESS<br><b>Baltimore, Md.</b>  |  |
| 18. CAUSE OF DEATH<br><b>420.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Coronary atherosclerosis left + right</b><br>DUE TO<br><b>Myocardial infarction acute + chronic</b><br>DUE TO<br><b>antecedent causes</b><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>unknown</b><br><b>2 &amp; 3 weeks</b> |
| 19A. DATE OF OPERATION<br><b>7</b>   |                                  | 19B. MAJOR FINDINGS OF OPERATION  |  |
| 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  |   |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                                  |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                       |  |
| 21F. HOW DID INJURY OCCUR?   |                                  |   |  |
| 22. I hereby certify that I attended the deceased from <b>July 1</b> , 1950, to <b>July 5</b> , 1950, that I last saw the deceased alive on <b>July 5</b> , 1950, and that death occurred at <b>1:35 a.m.</b> , from the causes and on the date stated above.  |                                  |   |  |
| 23A. SIGNATURE<br><b>John L. Wilson, Clinical Director</b>   |                                  | 23B. ADDRESS<br><b>U.S. Marine Hospital, Balto. Md.</b>   |  |
| 23C. DATE SIGNED   |                                  |   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                  | 24B. DATE<br><b>7-7-1950</b>  |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>LODNON PARK</b>   |                                  | 24D. LOCATION (City, town, or county) (State)<br><b>BALTO. MD.</b>  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 6 - 1950</b>  |                                  | REGISTRAR'S SIGNATURE<br><b>Wm. H. Jenkins &amp; Sons</b>   |  |
| 25. FUNERAL DIRECTOR<br><b>Wm. H. Jenkins &amp; Sons</b>   |                                  | ADDRESS<br><b>1905 York Rd. 94a</b>   |  |

MEDICAL CERTIFICATION

57450



BALTIMORE CITY & COUNTY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

|                       |  |                              |  |
|-----------------------|--|------------------------------|--|
| Name of Deceased      |  | Date of Death                |  |
| Age                   |  | Sex                          |  |
| Race                  |  | Marital Status               |  |
| Place of Birth        |  | Usual Residence              |  |
| Cause of Death        |  | Manner of Death              |  |
| Physician's Signature |  | Medical Examiner's Signature |  |
| Date of Certificate   |  | Place of Death               |  |

535  
50 5949  
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5949  
Registered No.

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>VERNON W. LONDON</b>   |                                  | 2. DATE OF DEATH<br><b>7-5-50</b>   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>YRS.</b>  |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO CITY</b> |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION <b>MERCY HOSPITAL,<br/>37 CALVERT &amp; SARATOGA ST.</b> |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTO. 18 MD. 9-01</b>                                     |   |
| C. Length of stay in Baltimore <b>LIFE</b> Yrs. Mos. Days  |                                  | D. STREET ADDRESS (If rural, give location)<br><b>903 EAST 41ST ST.</b>   |   |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>   | 8. DATE OF BIRTH<br><b>MAY 19, 1897</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>PROPRIETOR</b>   |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>BALSO CHAIR COMPANY</b>   |   |
| 13. FATHER'S NAME<br><b>CHARLES LONDON</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>WHITEFORD</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>yes WAR I</b>   |                                  | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><b>Mrs. EULAH LONDON</b>  |                                  | ADDRESS   |   |

|  |  |  |
|--|--|--|
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Posterior Coronary Occlusion</b><br>(A) DUE TO <b>a formidably mural thrombus of the vessel</b> | CAUSE OF DEATH<br><b>Posterior Coronary Occlusion</b><br>(B) DUE TO <b>Marked coronary atherosclerosis</b><br>(C) <b>Arteriosclerosis of left iliac and aorta</b><br><b>Arteriosclerosis of lower lobe left lung</b> | INTERVAL BETWEEN ONSET AND DEATH<br><b>Approx 8 days</b> |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |  |

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|--|---|---|
| 19A. DATE OF OPERATION<br><b>6-27-50</b>   | 19B. MAJOR FINDINGS OF OPERATION<br><b>PRE PYLORIC CHRONIC GASTRIC ULCER BENIGN</b>                       | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>Incomplete</b> |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |
| 22. I hereby certify that I attended the deceased from <b>6-21</b> , 19 <b>50</b> , to <b>7-5</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>7-5</b> , 19 <b>50</b> , and that death occurred at <b>8:00</b> Am., from the causes and on the date stated above. |   |   |
| 23A. SIGNATURE<br><b>J. H. Smelser</b>   | 23B. ADDRESS<br><b>Mercy Hospital</b>   | 23C. DATE SIGNED<br><b>7-5-50</b>   |

|  |   |   |  |
|--|---|---|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24B. DATE<br><b>July 8, 1950</b>                          | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Landon Park</b>  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Md</b> |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 6 - 1950</b>    | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b> | 25. FUNERAL DIRECTOR<br><b>Henry H. Jenkins - Smelter</b> | ADDRESS<br><b>4905 York Rd<br/>117a</b>                              |

29033

STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL

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240

50 5950

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 5950

Registered No. \_\_\_\_\_

|  |                               |  |   |  |   |
|--|-------------------------------|--|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>ROSE GORDON HAXALL</b>   |                               |  | 2. DATE OF DEATH<br><b>July 6, 1950</b>   |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                               |  | 4. USUAL RESIDENCE (Where deceased lived, if institution / residence before admission)<br>A. STATE <b>Md</b><br>B. COUNTY _____ |  |   |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Preston Apts</b>   |                               |  | 6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Balto.</b>                                   |  |   |
| 7. DATE OF STAY IN BALTIMORE<br><b>81</b>  |                               |  | 8. STREET ADDRESS (If rural, give location)<br><b>Preston Apts cor Preston + Guilford</b>                                       |  |   |
| 9. SEX<br><b>F</b>   | 10. COLOR OR RACE<br><b>W</b> | 11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b> | 12. DATE OF BIRTH<br><b>Feb 7 1869</b>  |  | 13. AGE (In years last birthday)<br><b>81</b> |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>---</b> |                               |  | 15. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>  |  |   |
| 16. FATHER'S NAME<br><b>Douglas H Gordon</b>   |                               |  | 17. MOTHER'S MAIDEN NAME<br><b>Anne Eliza Pleasant</b>  |  |   |
| 18. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)<br><b>No</b>          |                               |  | 19. SOCIAL SECURITY NO.<br><b>---</b>   |  |   |
| 20. INFORMANT<br><b>---</b>  |                               |  | 21. ADDRESS<br><b>---</b>   |  |   |

|  |  |  |
|--|--|--|
| 18. <b>422.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Anterior - salvosis</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Years 6 mos</b> |
| (A) DUE TO   |  |  |
| ANTECEDENT CAUSES<br>(B) DUE TO<br><b>Myocarditis</b>  |  |  |
| (C) DUE TO   |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>---</b>  |  |  |

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 19A. DATE OF OPERATION <b>0</b>  |  | 19B. MAJOR FINDINGS OF OPERATION<br><b>---</b>   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>---</b> | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>---</b> |  |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY<br><b>---</b>  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?<br><b>---</b>   |  |   |  |
| 22. I hereby certify that I attended the deceased from <b>Dec. 48</b> to <b>July 6, 1950</b> , that I last saw the deceased alive on <b>July 5, 1950</b> , and that death occurred at <b>7:50 AM</b> , from the causes and on the date stated above. |  |  |  |   |  |
| 23A. SIGNATURE<br><b>Henry H. Jenkins</b>  |  | 23B. ADDRESS<br><b>1201 N. Calvert St</b>  |  | 23C. DATE SIGNED<br><b>July 6, 1950</b>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 24B. DATE<br><b>July 8/50</b>  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>St Thomas</b>                                 | 24D. LOCATION (City, town, or county) (State)<br><b>Oving Mills Md</b> |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 6 - 1950</b>  |  | REGISTRAR'S SIGNATURE<br><b>Trustington Williams, M.D.</b>                             |  | 25. FUNERAL DIRECTOR<br><b>Henry H. Jenkins &amp; Sons Co 4925 York Rd</b>          |  |

93D

Dr. Henry M. Thomas Jr.  
1201 Calvert.

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5951  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

|  |                                    |  |  |  |   |
|--|------------------------------------|--|--|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>JOHN W YANCY (Vancey)</b>  |                                    |  | 2. DATE OF DEATH <b>July 2, 1950</b>   |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>Balto. City</b>   |                                    |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY _____ |  |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>Johns Hopkins Hospital</b>          |                                    |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>6-04</b>                         |  |   |
| C. Length of stay in Baltimore <b>19 Yrs.</b><br>Yrs. _____ Mos. _____ Days _____  |                                    |  | D. STREET ADDRESS (If rural, give location)<br><b>129 N. Wolfe Street</b>  |  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Colored</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Single</b> | 8. DATE OF BIRTH<br><b>7/4/1925</b>  |  | 9. AGE (In years last birthday)<br><b>24</b><br>H Under 1 Year _____ H Under 24 Hours _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Gr. School</b>               |                                    | 10B. KIND OF BUSINESS OR INDUSTRY _____                          | 11. BIRTHPLACE (State or foreign country)<br><b>Oxford N.C.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |
| 13. FATHER'S NAME<br><b>William Vancey</b>   |                                    |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Anna Moss</b>  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, oo or unknown) (If yes, give war or dates of service)<br><b>Yes War # 2</b> |                                    | 16. SOCIAL SECURITY NO. _____                                    | 17. INFORMANT ADDRESS<br><b>Dorothy Jackson 1028 E Monument St</b>   |  |   |

**CAUSE OF DEATH**

|  |   |
|--|---|
| 18. <b>581.0</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>(A) Fatty infiltration of liver and metabolic cirrhosis (581.0)</b><br><del>XXXX</del> | INTERVAL BETWEEN ONSET AND DEATH<br>_____ |
|--|---|

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 19A. DATE OF OPERATION _____   |  | 19B. MAJOR FINDINGS OF OPERATION _____   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____        |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____      |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____  |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR? _____  |  |

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

|  |                              |   |  |   |  |
|--|------------------------------|---|--|---|--|
| 23A. SIGNATURE<br><b>J. S. Fisher</b>                      |                              | 23B. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/> M.D. _____ |  | 23C. DATE SIGNED<br><b>July 3, 1950</b> |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24B. DATE<br><b>7/7/1950</b> | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Balto. Nat. Cem.</b>   | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore City</b> |   |  |

|   |  |  |
|---|--|--|
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 6 - 1950</b> | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, Jr.</b> | 25. FUNERAL DIRECTOR ADDRESS<br><b>Elroy O. Wilson 1000 Brantly Ave</b><br><b>Elroy O. Wilson 124 BL</b> |
|---|--|--|

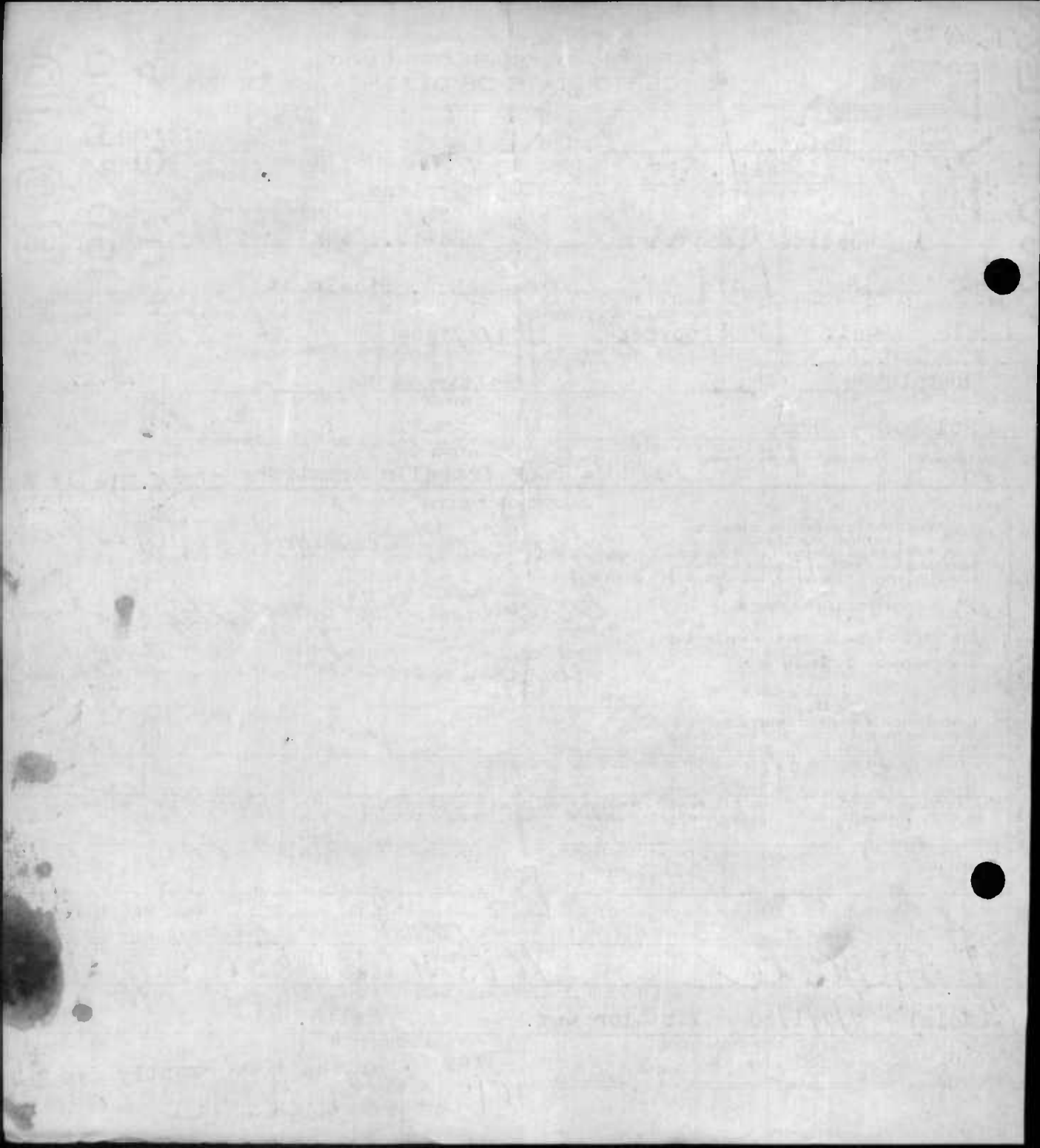




200  
5952BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5952  
Registered No.

|   |                                 |   |  |  |   |
|---|---------------------------------|---|--|--|---|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Solomon Chase</b>  |                                 |   | 2. DATE OF DEATH<br><b>7/3/1950</b>  |  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>Balto. City</b>  |                                 |   | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>262 West Biddle Street</b>  |                                 |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Balto. City</b>                             |  |   |
| Length of stay in Baltimore <b>Life</b>   |                                 |   | D. STREET ADDRESS (If rural, give location)<br><b>262 W. Biddle St</b>   |  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Col.</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Divorced</b>  | 8. DATE OF BIRTH<br><b>11/3/1886</b>   |  | 9. AGE (in years, last birthday)<br><b>63</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Unemployed</b>  |                                 |   | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore Md</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |
| 13. FATHER'S NAME<br><b>Solomon Chase</b>   |                                 |   | 14. MOTHER'S MAIDEN NAME<br><b>Emma ?</b>  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>No</b>  |                                 |   | 16. SOCIAL SECURITY NO.<br><b>218 14 8587</b>  |  |   |
| 17. INFORMANT<br><b>Isabelle Armstrong</b>  |                                 |   | ADDRESS<br><b>262 W. Biddle St.</b>  |  |   |
| 18. <b>491X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Brondio Pneumonia</b><br>DUE TO<br><b>Arthritis. TB Bronchitis 10-month</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>with Sinusitis - Indefinite</b><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                                 |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>8 weeks</b>   |  |   |
| 19A. DATE OF OPERATION <b>0</b>   |                                 |   | 19B. MAJOR FINDINGS OF OPERATION   |  |   |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                 |   |  |  |   |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                                 | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |                                 | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <b>6-1-50</b> to <b>7-3-50</b> , that I last saw the deceased alive on <b>7-3-50</b> , and that death occurred at <b>10:15 PM</b> , from the causes and on the date stated above.  |                                 |   |  |  |   |
| 23A. SIGNATURE<br><b>Car. R. Blake</b>  |                                 | 23B. ADDRESS<br><b>1603-4 Caroline St.</b>  |  | 23C. DATE SIGNED<br><b>7/6/50</b>  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                 | 24B. DATE<br><b>7/7/1950</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Mt Zion Cem.</b>                |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md</b>   |                                 | 25. FUNERAL DIRECTOR<br><b>Elroy O. Wilson</b>  |  |  |   |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 6 - 1950</b>   |                                 | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b>   |  | ADDRESS<br><b>1000 Brantly Ave</b>                                       |   |
| VS 150  |                                 | <b>Elroy O. Wilson 107</b>  |  |  |   |

MEDICAL CERTIFICATION



BALTO. CITY

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

50 5953

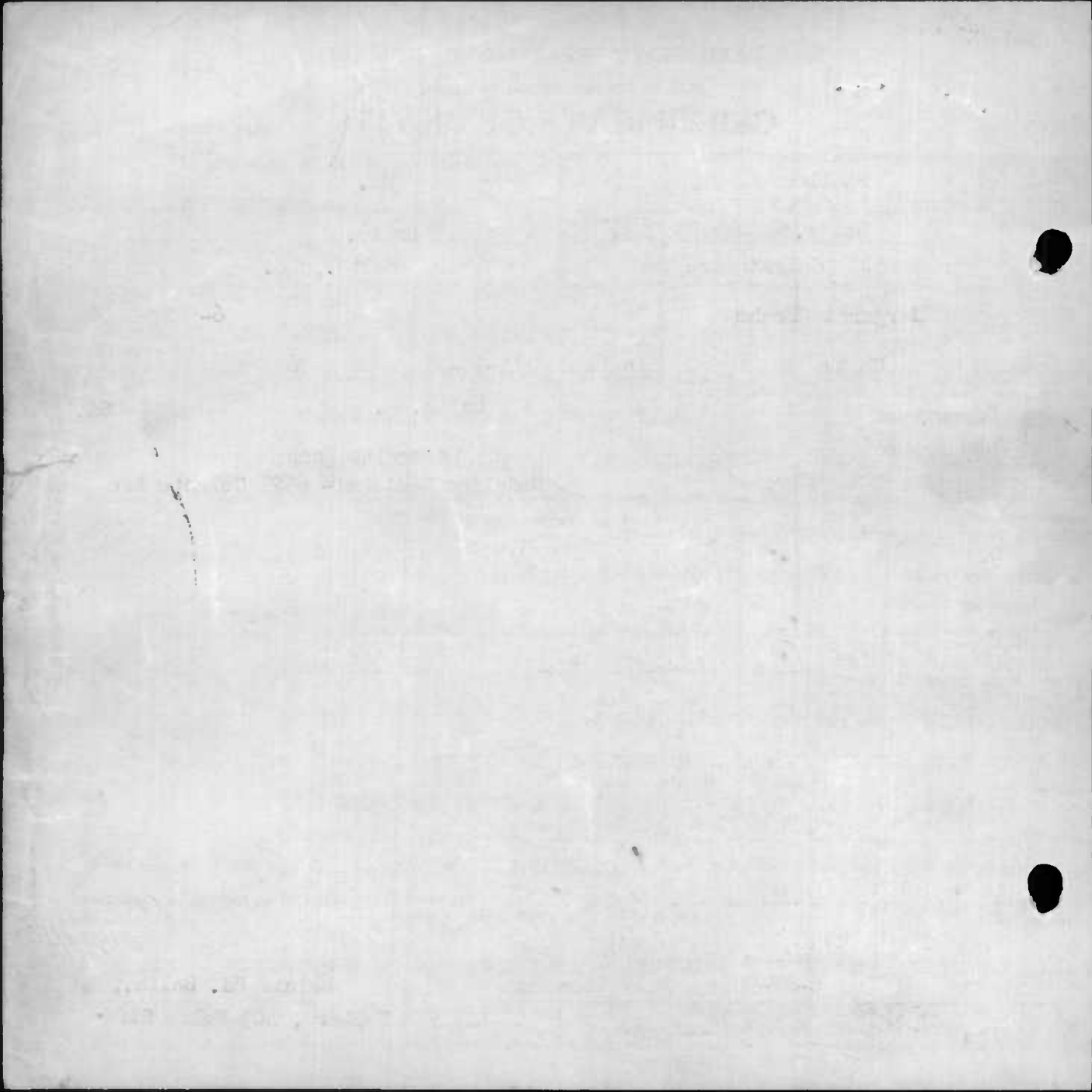
## CERTIFICATE OF DEATH

Reg. Dist. No. 41

|   |                           |  |   |   |   |
|---|---------------------------|--|---|---|---|
| PLACE OF DEATH-<br>COUNTY Baltimore   |                           | MARYLAND   |   | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE Md. COUNTY                              |   |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>Balto.                         |                           | LENGTH OF STAY<br>(in this place)<br>Life                  |   | CITY (If outside corporate limits, write RURAL and give nearest town)<br>Balto. Sundell |   |
| HOMERIAL OR<br>INSURANCE OR<br>STREET ADDRESS<br>6521 Colgate Ave                                       |                           |  |   | STREET ADDRESS<br>Balto., Md. 26-06   |   |
| NAME OF DECEASED<br>(Type or Print)<br>Margaret Brehm   |                           | (First) (Middle) (Last)                                    |   | 4. DATE OF DEATH<br>6-27-50 19  |   |
| SEX<br>Female   | 6. COLOR OR RACE<br>White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)<br>Single | 8. DATE OF BIRTH<br>11-19-73                            | 9. AGE last birthday<br>76 yrs.   | If under 1 year<br>Months Days Hours Min. |
| 10. USUAL OCCUPATION (Give kind of work one during most of working life, even if retired)<br>Seamstress |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>Self                  | 11. BIRTHPLACE (State or foreign country)<br>Balto. Md. |   | 12. CITIZEN OF WHAT COUNTRY?<br>USA.      |
| FATHER'S NAME<br>John Brehm   |                           | 14. MOTHER'S MAIDEN NAME<br>Gatherine Bach                 |   | 17. INFORMANT AND ADDRESS<br>Madeline Matthai- 6521 Colgate Ave                         |   |
| 13. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(If year, give war or dates of service)                  |                           | 16. SOCIAL SECURITY No.                                    |   |   |   |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 18. MEDICAL CERTIFICATION   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  |   |  |  |  |
| Immediate cause<br>(a) Cardiovascular disease   |  |   |  |  |  |
| Antecedent cause(s)<br>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last<br>(b) Hypertension<br>(c) Cardiac Hypertrophy                                    |  |   |  |  |  |
| OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |  |
| ACCIDENT SUICIDE HOMICIDE (Specify)   |  | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY                                 |  | (CITY OR TOWN) (COUNTY) (STATE)  |  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> |  | HOW DID INJURY OCCUR?  |  |
| 2. I hereby certify that I attended the deceased from 6/15/50, to 6/27/50, that I last saw the deceased at 6/27/50, 1950, and that death occurred at 50 m., from the causes and on the date stated above. |  |   |  |  |  |
| SIGNATURE<br>Samuel Gilbert   |  | (Degree or title)<br>M.D.   |  | ADDRESS<br>6006 Eastern Ave  |  |
| DATE SIGNED<br>6/27/50  |  |   |  |  |  |
| BURIAL, CREMATION, REMOVAL (Specify)  |  | DATE<br>6-29-50   |  | NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer                           |  |
|   |  |   |  | LOCATION (City, town, or county) (State)<br>Belair Rd. Balto., Md        |  |
| DATE REC'D BY LOCAL REG.<br>6-29-50   |  | REGISTRAR'S SIGNATURE<br>Huntington Williams, M.D.  |  | 24. FUNERAL DIRECTOR<br>Lilly & Zeller, 403 Wolfe Str                    |  |

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50 5954

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5954

Registered No.

BIRTH NO.

|   |                                    |   |  |
|---|------------------------------------|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>HATTIE</b>  |                                    | 2. DATE OF DEATH <b>July 5, 1950</b>  |  |
| 3. PLACE OF DEATH:<br>a. Baltimore City, Maryland <b>Balto. City</b>  |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore</b> |  |
| b. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>Provident Hospital</b>     |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>15-01</b>  |  |
| 5. LENGTH OF stay in Baltimore <b>3 Yrs.</b>  |                                    | d. STREET ADDRESS (If rural, give location)<br><b>1642 N. Gilmore Street</b>  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Colored</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Single</b>  | 8. DATE OF BIRTH<br><b>Jan. 13, 1922</b>     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Domestic</b>        |                                    | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Private Family</b>  | 9. AGE (In years last birthday)<br><b>28</b> |
| 13. FATHER'S NAME<br><b>Ed Jones</b>  |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>Crisfield Maryland</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b> |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 16. SOCIAL SECURITY NO.   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Maggie Jones</b>   |  |
| 17. INFORMANT<br><b>Cassie Brittenham</b>   |                                    | ADDRESS<br><b>1719 Westwood Ave</b>   |  |

|  |  |                                  |
|--|--|----------------------------------|
| 18. <b>023X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Stenosis of coronary ostia due to syphilitic aortitis</b> |  | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>(A) DUE TO</b>  |  |                                  |
| <b>(B) DUE TO</b>  |  |                                  |
| <b>(C) DUE TO</b>  |  |                                  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |                                  |

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21f. HOW DID INJURY OCCUR?  |  |
| 22. I certify that I took charge of the remains described above, held an <u>Autopsy</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <u>natural causes</u> <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . |  |  |  |   |  |
| 23a. SIGNATURE<br><b>RS Fisher</b>   |  | 23b. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/> |  | 23c. DATE SIGNED<br><b>7-5-50</b>   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24b. DATE<br><b>7/9/1950</b>   |  | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Lawsonia Cem.</b>                          |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 7 - 1950</b>  |  | REGISTRAR'S SIGNATURE<br><b>Elroy J. Wilson</b>  |  | 25. FUNERAL DIRECTOR<br><b>Elroy J. Wilson</b>                                      |  |
|  |  |  |  | ADDRESS<br><b>1000 Brantly Ave</b>  |  |

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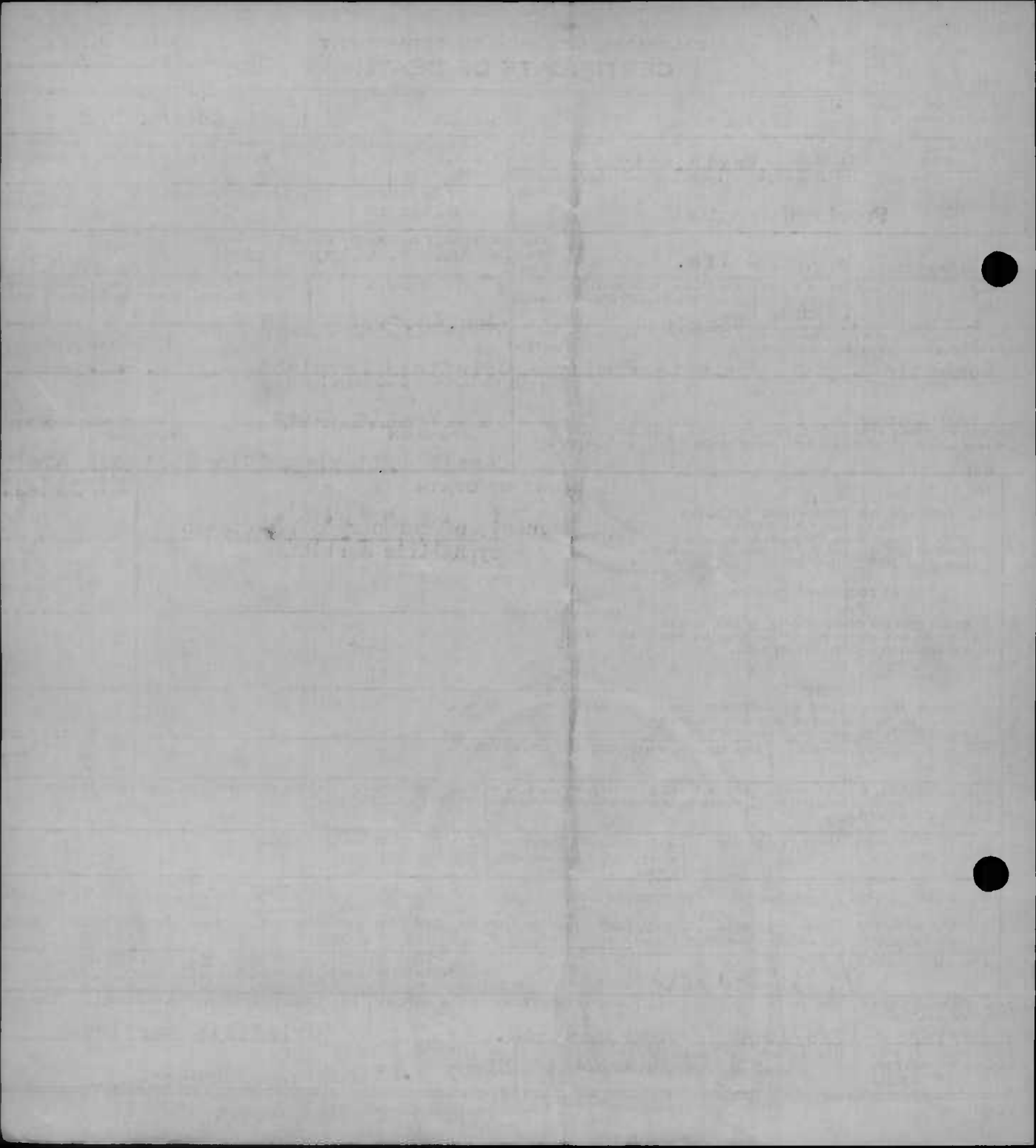
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Elroy J. Wilson

30D ✓

MEDICAL CERTIFICATION





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DEALE

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5955

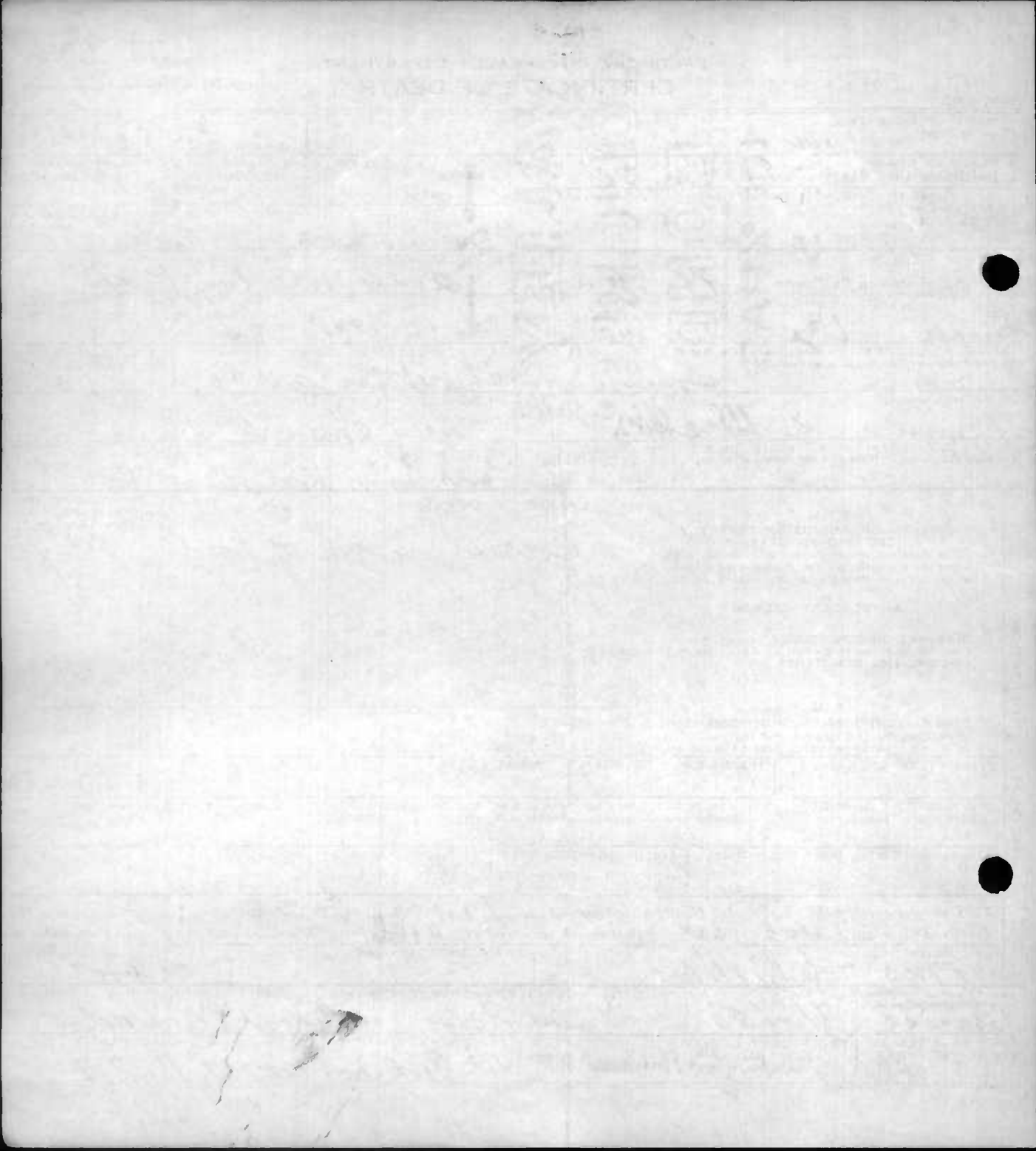
50 5955  
BIRTH NO.

Registered No.

|  |  |   |  |
|--|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Mary A. Deale</i>  |  | 2. DATE OF DEATH <i>July 6, 1950</i>  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>2129 N. Calvert</i>                                       |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <i>md.</i> B. COUNTY <i>12-04</i> |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><i>2129 N. Calvert</i> |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore md</i>                                 |  |
| D. STREET ADDRESS (If rural, give location)<br><i>2129 N. Calvert St.</i>                                      |  |   |  |
| 5. SEX <i>Female</i>   |  | 6. COLOR OR RACE <i>white</i>   |  |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>widow</i>  |  | 8. DATE OF BIRTH <i>Jan 12, 1865</i>  |  |
| 9. AGE (In years last birthday) <i>85</i>  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Home</i>                           |  |
| 11. BIRTHPLACE (State or foreign country)<br><i>Churektown D.C.</i>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>usa</i>  |  |
| 13. FATHER'S NAME<br><i>Thomas S. Weeks</i>  |  | 14. MOTHER'S MAIDEN NAME<br><i>Mary Keenan</i>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><i>no</i>               |  | 16. SOCIAL SECURITY NO.<br><i>none</i>  |  |
| 17. INFORMANT<br><i>Mrs. Lila F. Smart</i>   |  | ADDRESS<br><i>Daughters</i>   |  |

|   |                                |   |
|---|--------------------------------|---|
| 18. <i>156.1</i>  | CAUSE OF DEATH                 | INTERVAL BETWEEN ONSET AND DEATH<br><i>one year 10 days</i> |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | (A) <i>Carcinoma of Liver.</i> |   |
| ANTECEDENT CAUSES   | (B)                            |   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   | (C)                            |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                                |   |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 19A. DATE OF OPERATION <i>0</i>   |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <i>1940</i> , 19 <i>40</i> , to <i>July 6</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>July 5</i> , 19 <i>50</i> , and that death occurred at <i>11:55 PM</i> from the causes and on the date stated above. |  |   |  |  |  |
| 23A. SIGNATURE<br><i>Mrs. H. Phillips</i>   |  | 23B. ADDRESS<br><i>29 N.</i>  |  | 23C. DATE SIGNED<br><i>July 6 - 50</i>                                   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  | 24B. DATE<br><i>7/8/50</i>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Druid Ridge</i>                 |  |
| 24D. LOCATION (City, town, or county)<br><i>Pikesville Md.</i>  |  | 24E. NAME OF CEMETERY OR CREMATORY<br><i>Druid Ridge</i>  |  | 24F. LOCATION (City, town, or county)<br><i>Pikesville Md.</i>           |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUL 7 - 1950</i>   |  | REGISTRAR'S SIGNATURE<br><i>Huntington Williams, M.D.</i>   |  | 25. FUNERAL DIRECTOR<br><i>Wm. Cook Inc. 1217 St. Paul St.</i>           |  |



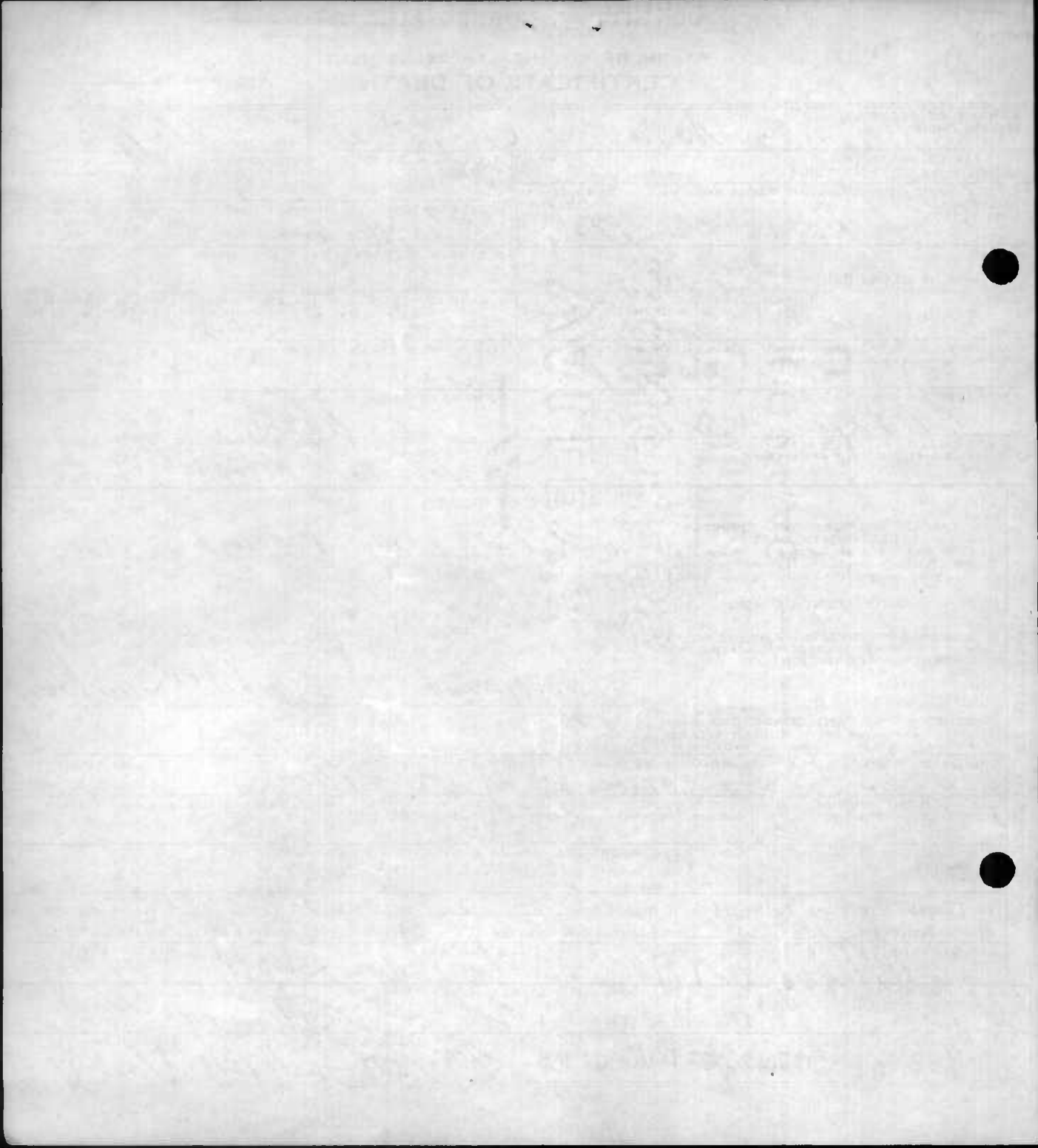
|   |                           |   |  |
|---|---------------------------|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Charles Nolan Becker</i>  |                           | 2. DATE OF DEATH <i>7/5/50</i>  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                           | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>W-Va</i> B. COUNTY <i>V-45</i> |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br><i>Church Home Hospital</i> |                           | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Charles Town</i>                                 |  |
| Length of stay in Baltimore <i>9 Days</i>   |                           | D. STREET ADDRESS (If rural, give location)   |  |
| 5. SEX <i>M</i>   | 6. COLOR OR RACE <i>W</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>  | 8. DATE OF BIRTH <i>Mar. 28, 1876</i>                        |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FARMER</i>           |                           | 10B. KIND OF BUSINESS OR INDUSTRY <i>Retired self</i>   | 9. AGE (In years last birthday) <i>73</i>                    |
| 13. FATHER'S NAME <i>Charles Becker</i>   |                           | 11. BIRTHPLACE (State or foreign country) <i>W-Va</i>   | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)  |                           | 16. SOCIAL SECURITY NO.   | 17. INFORMANT <i>Hospital Record</i> ADDRESS <i>Deceased</i> |

|  |                                 |                                  |
|--|---------------------------------|----------------------------------|
| 18. <i>181X</i>  | CAUSE OF DEATH                  | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) <i>Pulmonary Edema</i>      | <i>1 day</i>                     |
| ANTECEDENT CAUSES  | (B) <i>Uremia</i>               | <i>3 days</i>                    |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, (A) STATING THE UNDERLYING CONDITION LAST.   | (C) <i>Carcinoma of Bladder</i> | <i>unknown</i>                   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                                 |                                  |

|  |  |  |
|--|--|--|
| 19A. DATE OF OPERATION <i>6/30/50</i>        | 19B. MAJOR FINDINGS OF OPERATION <i>Carcinoma of Bladder</i>   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>    |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |

22. I hereby certify that I attended the deceased from *6-27*, 19*50*, to *7-5*, 19*50*, that I last saw the deceased alive on *7-5*, 19*50*, and that death occurred at *6:26 PM*, from the causes and on the date stated above.

|   |  |   |
|---|--|---|
| 23A. SIGNATURE <i>W. H. ...</i>                           | 23B. ADDRESS <i>Church Home Hospital</i> | 23C. DATE SIGNED <i>7/5/50</i>                        |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>   | 24B. DATE <i>7/8/50</i>                  | 24C. NAME OF CEMETERY OR CREMATORY <i>London Park</i> |
| 24D. LOCATION (City, town, or county) <i>Baltimore Md</i> | 25. FUNERAL DIRECTOR <i>W. H. ...</i>    | ADDRESS <i>1214 St Paul St</i>                        |



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 5957

|   |                           |   |                                   |  |                                  |
|---|---------------------------|---|-----------------------------------|--|----------------------------------|
| BIRTH NO.   |                           | 1. NAME OF DECEASED<br>(Type or Print)  |                                   | 2. DATE OF DEATH   |                                  |
|   |                           | JOSEPH H. TOLSON  |                                   | July 5, 1950   |                                  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                           | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE<br>Maryland |                                   | B. COUNTY  |                                  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION<br>421 S. Chester St.   |                           | C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)<br>Baltimore                    |                                   | 1-05   |                                  |
| C. Length of stay in Baltimore<br>Yrs.<br>Mos.<br>Days  |                           | D. STREET ADDRESS (If rural, give location)<br>421 S. Chester St.   |                                   |  |                                  |
| 5. SEX<br>Male  | 6. COLOR OR RACE<br>White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>Widower  | 8. DATE OF BIRTH<br>Apr. 22, 1865 | 9. AGE (In years, last birthday)<br>85 84                                | 10. Under 1 Year<br>Months: Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Janitor retired  |                           | 10B. KIND OF BUSINESS OR INDUSTRY<br>Balto city Schools   |                                   | 11. BIRTHPLACE (State or foreign country)<br>Maryland                    |                                  |
| 12. CITIZEN OF WHAT COUNTRY?  |                           | 13. FATHER'S NAME<br>Unknown Joseph D. Tolson   |                                   | 14. MOTHER'S MAIDEN NAME<br>Unknown Sarah E. Carville                    |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br>No   |                           | 16. SOCIAL SECURITY NO.<br>None   |                                   | 17. INFORMANT ADDRESS<br>Sarah E. Krouse, 113 S. Morley St.              |                                  |
| 18. 422.1<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br>(A) Cardiac vascular disease - Sudden death<br>DUE TO<br>(B)<br>DUE TO<br>(C)<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                           | INTERVAL BETWEEN ONSET AND DEATH  |                                   |  |                                  |
| 19A. DATE OF OPERATION 0  |                           | 19B. MAJOR FINDINGS OF OPERATION  |                                   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                      |                                   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                  |
| 21D. TIME (Month) (Day) (Year) (Hour)<br>INJURY   |                           | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>     |                                   | 21F. HOW DID INJURY OCCUR?   |                                  |
| 22. I hereby certify that I attended the deceased from July 4, 1950, to July 5, 1950, that I last saw the deceased alive on July 4, 1950, and that death occurred at 11:20 p.m., from the causes and on the date stated above.  |                           |   |                                   |  |                                  |
| 23A. SIGNATURE<br>Lois A. Lefsky  |                           | 23B. ADDRESS<br>421 S. Chester St. Baltimore, Md.   |                                   | 23C. DATE SIGNED<br>7/6/50   |                                  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                           | 24B. DATE<br>7/8/50   |                                   | 24C. NAME OF CEMETERY OR CREMATORY<br>Stevensville                       |                                  |
| 24D. LOCATION (City, town, or county) (State)<br>Stevensville, Md.  |                           | 24E. FUNERAL DIRECTOR<br>William C. Jones   |                                   | 24F. ADDRESS<br>1214 ST Paul St  |                                  |
| DATE RECEIVED BY LOCAL REGISTRAR<br>JUL 7 - 1950  |                           | REGISTRAR'S SIGNATURE<br>Huntington Williams, M.D.  |                                   |  |                                  |



WATERS

CERTIFICATE OF DEATH

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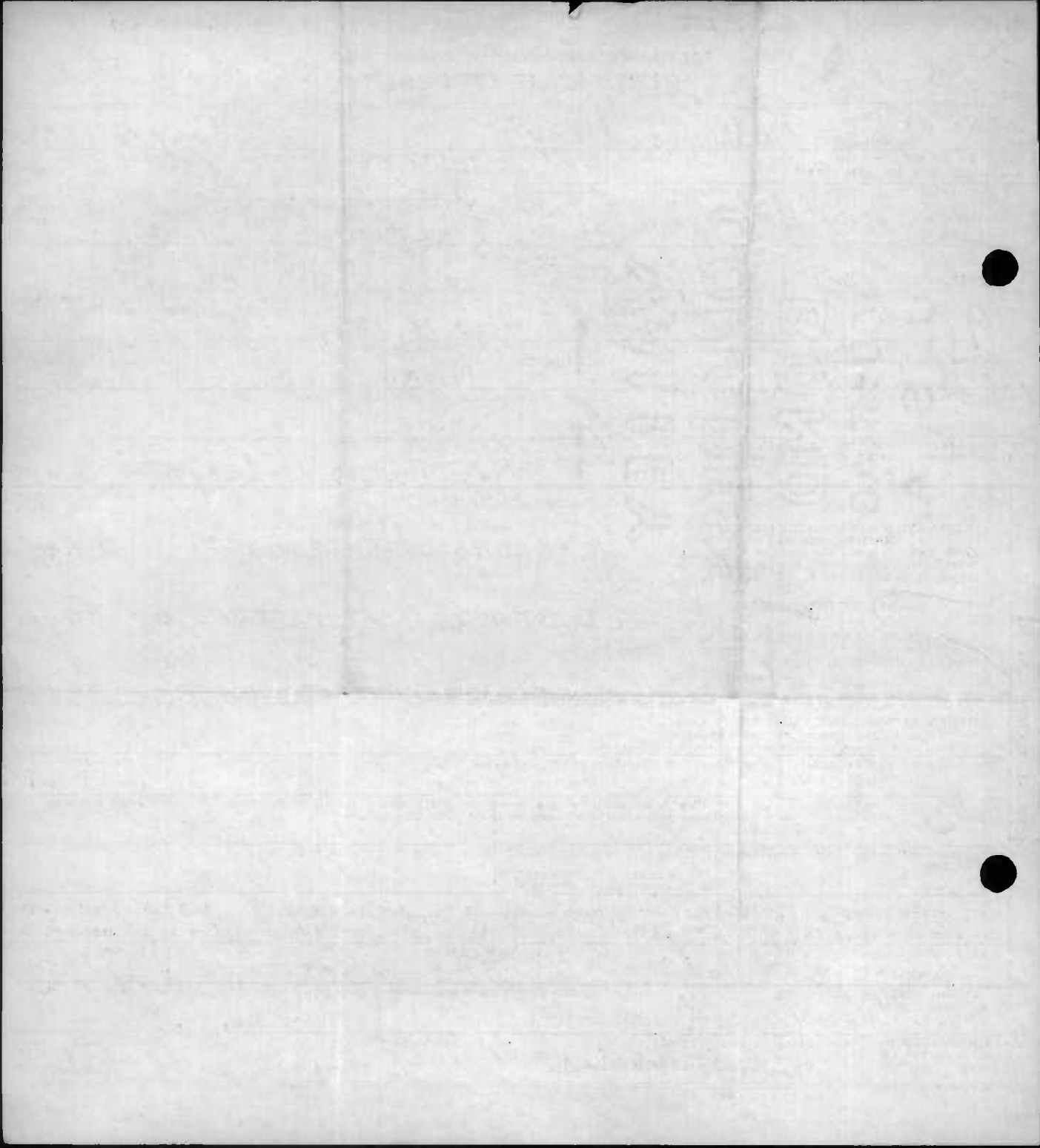
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5958

|   |                           |  |                                       |
|---|---------------------------|--|---------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>EUGENE MACDONALD LLOYD.</b>   |                           | 2. DATE OF DEATH <b>JULY 4, 1950</b>   |                                       |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                           | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>MD.</b><br>B. COUNTY <b>-</b> |                                       |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>1204 N. ST. PAUL ST.</b> |                           | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTIMORE 11-02</b>                             |                                       |
| C. Length of stay in Baltimore <b>14 YRS</b>  |                           | D. STREET ADDRESS (If rural, give location)<br><b>1204 N. ST. PAUL ST.</b>   |                                       |
| 5. SEX <b>M</b>   | 6. COLOR OR RACE <b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>M</b>   | 8. DATE OF BIRTH <b>Nov. 18, 1885</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>MECH. ENGINEER</b>                        |                           | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Const.</b>   |                                       |
| 13. FATHER'S NAME<br><b>A. PARLETT LLOYD</b>  |                           | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                    |                           | 16. SOCIAL SECURITY NO.  |                                       |
| 17. INFORMANT<br><b>MRS. MARTHA W. LLOYD - SAME</b>   |                           | ADDRESS  |                                       |

|   |   |                                  |
|---|---|----------------------------------|
| 18. <b>331X</b>   | CAUSE OF DEATH                          | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) <b>CEREBRAL HEMORRHAGE</b>          | <b>3 HRS.</b>                    |
| ANTECEDENT CAUSES   | (B) <b>ESSENTIAL HYPERTENSION</b>       | <b>20 YRS.</b>                   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   | (C) <b>GENERALIZED ARTERIOSCLEROSIS</b> |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |   |                                  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 19A. DATE OF OPERATION <b>0</b>   |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>JULY 4, 1950</b> , to <b>JULY 4, 1950</b> , that I last saw the deceased alive on <b>JULY 4, 1950</b> , and that death occurred at <b>12:30 p. m.</b> , from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE<br><b>Henry J. Housko</b>  |  | 23B. ADDRESS<br><b>333 S. EAST AVE</b>  |  | 23C. DATE SIGNED<br><b>7/4/50</b>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>7/6/50</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge</b>                            |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Pikesville, Md.</b>   |  | 25. FUNERAL DIRECTOR<br><b>W. W. Meador</b>   |  |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 7 - 1950</b>   |  | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, MD</b>   |  | ADDRESS<br><b>Don 805 N. Calver St.</b>   |  |



CLARENCE O.W. MANN

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)2. DATE  
OF  
DEATH

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE B. COUNTY before admission)

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 590X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/10, 1950, to 7/8, 1950, that I last saw the  
deceased alive on 7/8, 1950, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

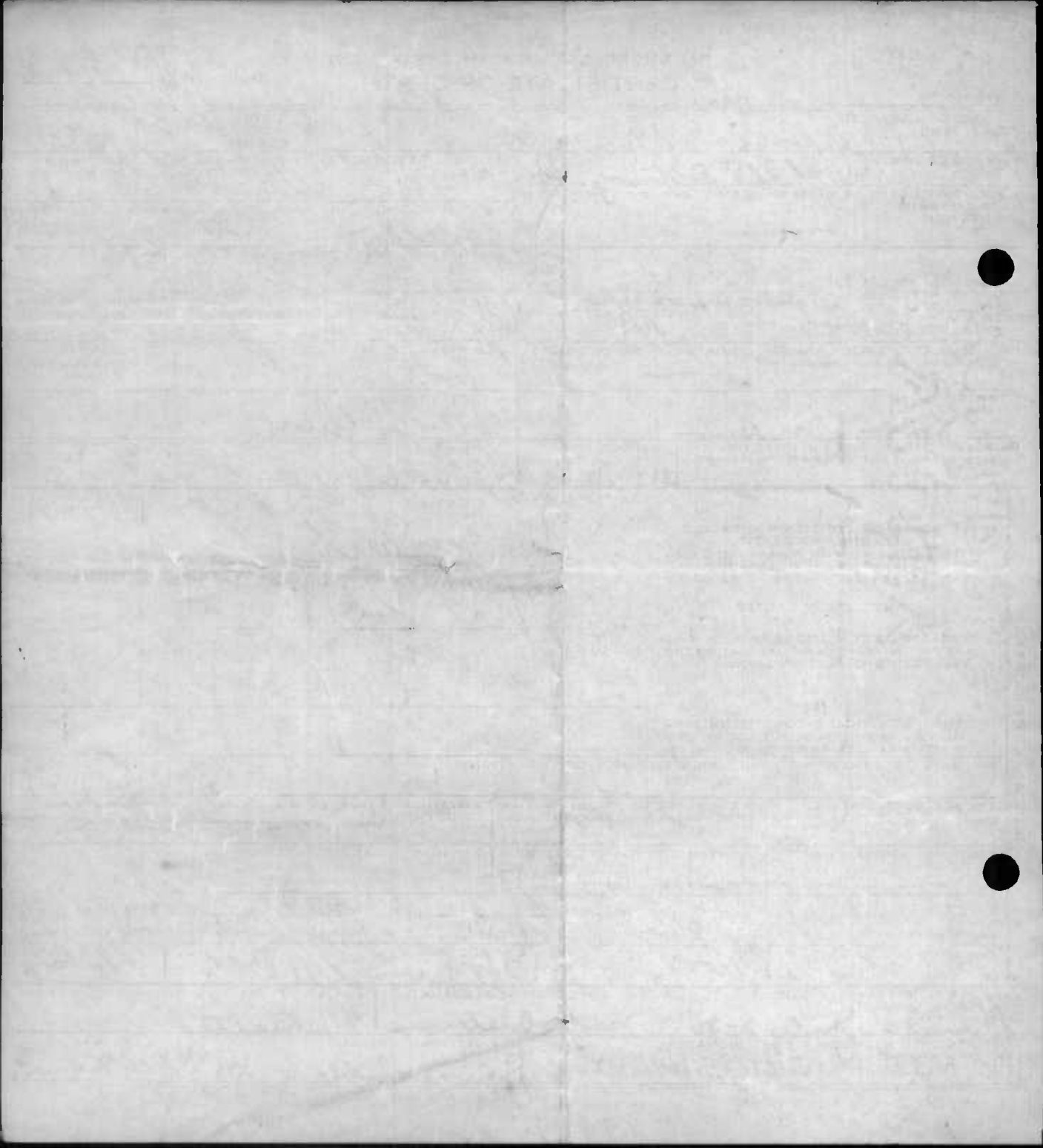
ADDRESS

VS 150

97099059

130

MEDICAL CERTIFICATION



42650 5960

50 5960

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

|   |                                  |   |                                       |  |  |
|---|----------------------------------|---|---------------------------------------|--|--|
| BIRTH NO. _____   |                                  | 1. NAME OF DECEASED<br>(Type or Print) <b>HARRY GLAZER</b>  |                                       | 2. DATE OF DEATH <b>JULY 6, 1950</b>                       |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO.</b> |                                       |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b>  |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>BALTIMORE 28-01</b>                                    |                                       |  |  |
| C. Length of stay in Baltimore <b>48</b>  |                                  | D. STREET ADDRESS (If rural, give location)<br><b>4307 RIDGEWOOD AVE. (15)</b>  |                                       |  |  |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>MARRIED</b>   | 8. DATE OF BIRTH<br><b>JUNE, 1886</b> | 9. AGE (In years last birthday)<br><b>64</b>               | 10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>SERVICE STATION</b>   |                                       | 11. BIRTHPLACE (State or foreign country)<br><b>RUSSIA</b> |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                  | 13. FATHER'S NAME<br><b>LOUIS GLAZER</b>  |                                       | 14. MOTHER'S MAIDEN NAME<br><b>REBECCA LIPSCHITZ</b>       |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)<br><b>NO</b>                                 |                                  | 16. SOCIAL SECURITY NO. _____   |                                       | 17. INFORMANT<br><b>MR. LEON GLAZER</b>                    |  |
|   |                                  |   |                                       | ADDRESS<br><b>3012 DANKFORD AVE., BALTO. MD.</b>           |  |

MEDICAL CERTIFICATION

|  |  |
|--|--|
| 18. <b>420.0</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br>(A) <b>Hypertensive and arteriosclerotic heart disease</b><br>DUE TO<br>(B) <b>Generalized arteriosclerosis, marked</b><br>DUE TO<br>(C) _____<br>INTERVAL BETWEEN ONSET AND DEATH |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |

|  |   |  |
|--|---|--|
| 19A. DATE OF OPERATION <b>0</b>              | 19B. MAJOR FINDINGS OF OPERATION  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |

22. I hereby certify that I attended the deceased from **JUNE 22, 1950**, to **JULY 6, 1950**, that I last saw the deceased alive on **JULY 6, 1950**, and that death occurred at **2:15 A.M.**, from the causes and on the date stated above.

|   |   |                                   |
|---|---|-----------------------------------|
| 23A. SIGNATURE<br><b>Dr. F. Cox 3rd</b> | 23B. ADDRESS<br><b>Union Memorial Hosp.</b> | 23C. DATE SIGNED<br><b>7/6/50</b> |
|---|---|-----------------------------------|

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24B. DATE<br><b>July 7, 1950</b> | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Rosedale</b> | 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b> |
|--|----------------------------------|---|--|

|   |   |   |         |
|---|---|---|---------|
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 7 - 1950</b> | REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b> | 25. FUNERAL DIRECTOR<br><b>Paul Lewis Inc. - 2100 Eastern Pk.</b> | ADDRESS |
|---|---|---|---------|

2906K 5961

93D



CERTIFICATE OF MARRIAGE

State of New York

County of \_\_\_\_\_

On the \_\_\_\_\_ day of \_\_\_\_\_

19\_\_\_\_

I, \_\_\_\_\_

Minister of the Gospel of the \_\_\_\_\_

Church of the \_\_\_\_\_

do hereby certify that \_\_\_\_\_

and \_\_\_\_\_

have been by me lawfully joined together in Holy Matrimony

according to the rites and ceremonies of the \_\_\_\_\_

and the laws of the State of New York.

In testimony whereof, I have hereunto set my hand and the seal of my office

at \_\_\_\_\_

this \_\_\_\_\_ day of \_\_\_\_\_

19\_\_\_\_

\_\_\_\_\_

Minister of the Gospel of the \_\_\_\_\_

Church of the \_\_\_\_\_

do hereby certify that \_\_\_\_\_

and \_\_\_\_\_

have been by me lawfully joined together in Holy Matrimony

according to the rites and ceremonies of the \_\_\_\_\_

and the laws of the State of New York.

In testimony whereof, I have hereunto set my hand and the seal of my office

at \_\_\_\_\_

this \_\_\_\_\_ day of \_\_\_\_\_

19\_\_\_\_

\_\_\_\_\_

Minister of the Gospel of the \_\_\_\_\_

Church of the \_\_\_\_\_

do hereby certify that \_\_\_\_\_

and \_\_\_\_\_

have been by me lawfully joined together in Holy Matrimony

according to the rites and ceremonies of the \_\_\_\_\_

and the laws of the State of New York.

In testimony whereof, I have hereunto set my hand and the seal of my office

at \_\_\_\_\_

this \_\_\_\_\_ day of \_\_\_\_\_

19\_\_\_\_

\_\_\_\_\_

300  
50 5961

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5961  
Registered No.

|  |                                    |  |  |
|--|------------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Annie Redd</b>   |                                    | 2. DATE OF DEATH <b>JUL 6 - 1950</b>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>Opel</b>  |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY   |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>JOHNS HOPKINS HOSPITAL</b>   |                                    | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 11-03</b>                   |  |
| C. Length of stay in Baltimore <b>24 Yrs.</b>  |                                    | D. STREET ADDRESS (If rural, give location)<br><b>421 W. MONUMENT ST.</b>  |  |
| 5. SEX<br><b>female</b>  | 6. COLOR OR RACE<br><b>colored</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>M</b>  | 8. DATE OF BIRTH<br><b>2-15-06</b>           |
| 9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                    | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>  | 9. AGE (In years last birthday)<br><b>44</b> |
| 11. BIRTHPLACE (State or foreign country)<br><b>Norfolk Virginia</b>   |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>William Parker</b>   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Josephine Butts</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)<br><b>No</b>  |                                    | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT<br><b>JOHNS HOPKINS HOSPITAL</b>   |                                    | ADDRESS  |  |
| 18. <b>443 X</b> <b>002 X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>UREMIA SEVERE NEPHROSCLEROSIS</b><br><b>Arteriosclerotic HYPERTENSIVE</b><br><b>cardiovascular Disease</b><br>DUE TO<br>(A) <b>Arteriosclerotic HYPERTENSIVE</b><br>DUE TO<br>(B) <b>cardiovascular Disease</b><br>DUE TO<br>(C) |                                    | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 mos</b><br><b>Unknown</b><br><b>13 YEARS</b><br><b>Unknown</b><br><b>(over)</b> |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>TOC. OF LEFT LUNG APEX</b><br><b>Pulmonary Fibrosis? Tuberculosis</b>  |                                    | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                      |  |
| 19A. DATE OF OPERATION <b>7-6-50</b>   |                                    | 19B. MAJOR FINDINGS OF OPERATION<br><b>None</b>  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |                                    | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                 |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                                    | 21D. TIME (Month) (Day) (Year) (Hour) INJURY   |  |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                                    | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <b>6-30-1950</b> to <b>7-6-1950</b> , that I last saw the deceased alive on <b>7-6-1950</b> and that death occurred at <b>1:33 Pm.</b> , from the causes and on the date stated above.  |                                    |  |  |
| 23A. SIGNATURE<br><b>Thomas E. Van Meter</b> M. D.   |                                    | 23B. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>  |  |
| 23C. DATE SIGNED<br><b>6 July 50</b>   |                                    | 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |
| 24B. DATE<br><b>7/9/1950</b>   |                                    | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Francis Cherry Cem.</b>   |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Norfolk Virginia</b>   |                                    | 25. FUNERAL DIRECTOR<br><b>Eloy O. Wilson</b>  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 7 - 1950</b>  |                                    | REGISTRAR'S SIGNATURE<br><b>Washington Williams, M.D.</b>  |  |
| VS 150   |                                    | ADDRESS<br><b>Eloy O. Wilson 1000 Brantly Ave</b>  |  |

13 B

Amendment from autopsy, old history, etc

See Document File 50 - 5961

8-24-50

Es

-613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

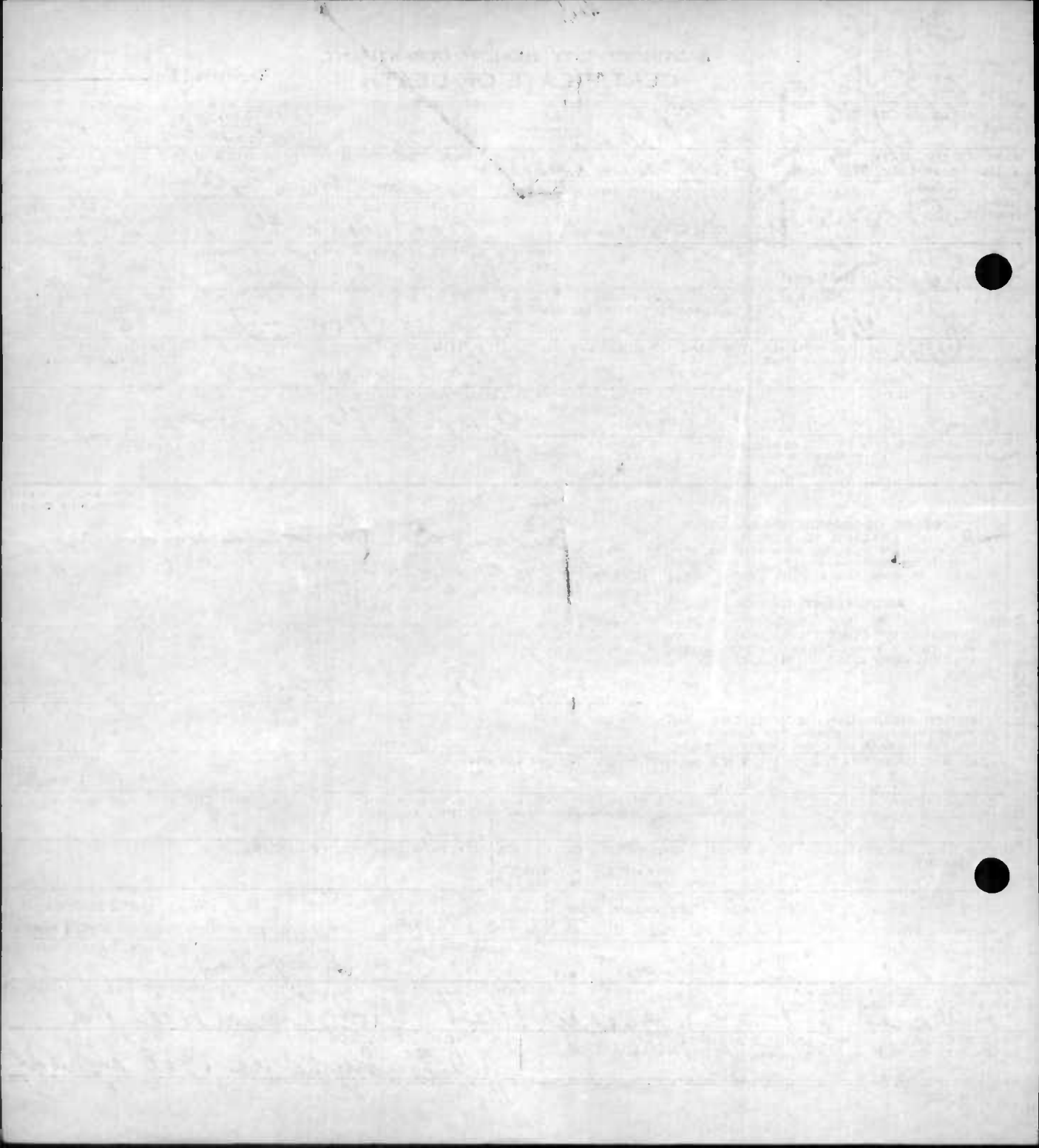
Registered No. 50 5962

50 5962  
BIRTH NO. 50-13656 John

|  |                                   |  |  |
|--|-----------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>J. R. FF:ths Robert</i>  |                                   | 2. DATE OF DEATH<br><i>July 4, 1950</i>  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>Balt. more md</i>                                       |                                   | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <i>Balt</i> B. COUNTY <i>MCK</i> |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>Mercy Hospital</i>   |                                   | C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)<br><i>Balt. more 26-05</i>                           |  |
| C. Length of stay in Baltimore <i>5</i>  |                                   | D. STREET ADDRESS (If rural, give location)<br><i>608 S. SAUNG ST.</i>   |  |
| 5. SEX<br><i>Male</i>  | 6. COLOR OR RACE<br><i>Wh. to</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  | 8. DATE OF BIRTH<br><i>June 29, 1950</i>   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>infant</i> |                                   | 10B. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (In years, last birthday) <i>5 days</i><br>If Under 1 Year: Months: Days: Hours: Min. |
| 11. BIRTHPLACE (State or foreign country)<br><i>Balt. more, MD.</i>  |                                   | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME<br><i>Will. R. M. J. R. FF:th</i>  |                                   | 14. MOTHER'S MAIDEN NAME<br><i>GRACE WEBNER</i>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>                                  |                                   | 16. SOCIAL SECURITY NO. <i>no</i>  |  |
| 17. INFORMANT  |                                   | ADDRESS  |  |

|  |   |   |
|--|---|---|
| 18. <i>756.2</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Congenital Abnormalities</i><br>(A) <i>GASTRO-INTESTINAL TRACT</i><br><i>URINARY TRACT, etc</i><br>ANTECEDENT CAUSES<br>(B) <i>PRE MATURITY</i><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(C) <i>PRE MATURITY</i><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | CAUSE OF DEATH<br><i>Congenital Abnormalities</i><br><i>GASTRO-INTESTINAL TRACT</i><br><i>URINARY TRACT, etc</i><br><i>PRE MATURITY</i> | INTERVAL BETWEEN ONSET AND DEATH<br><i>5 days</i> |
|--|---|---|

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 19A. DATE OF OPERATION <i>0</i>  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <i>July 4, 1950</i> , to <i>July 4, 1950</i> , that I last saw the deceased alive on <i>July 4, 1950</i> , and that death occurred at <i>7:30 P. M.</i> , from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE<br><i>M. E. Muller</i>  |  | 23B. ADDRESS<br><i>Mercy Hospital</i>   |  | 23C. DATE SIGNED<br><i>July 4, 1950</i>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  | 24B. DATE<br><i>7-7-50</i>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Sacred Heart</i>                           |  |
| 24D. LOCATION (City, town, & county)<br><i>German Hill Rd</i>  |  | 24E. (State) <i>MD</i>  |  | 25. FUNERAL DIRECTOR<br><i>J. J. Trahey &amp; Sons 1318 Light St</i>                |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUL 7 - 1950</i>  |  | REGISTRAR'S SIGNATURE<br><i>Thurston Williams, M.D.</i>   |  | ADDRESS   |  |



50 5963

FENN  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5963

Registered No.

BIRTH NO.

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Mary E. Penn</i>  |                                  | 2. DATE OF DEATH<br><i>July 4-1950</i>  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>2903 Shirley Ave.</i>   |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 27-03</i>                      |  |
| C. Length of stay in Baltimore<br>Yrs. Mos. Days  |                                  | D. STREET ADDRESS (If rural, give location)<br><i>2903 Shirley Avenue</i>   |  |
| 5. SEX<br><i>Female</i>   | 6. COLOR OR RACE<br><i>white</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>widowed</i>   | 8. DATE OF BIRTH<br><i>Mar. 10, 1858</i>       |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>at home</i> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (In years - last birthday)<br><i>92</i> |
| 11. BIRTHPLACE (State or foreign country)<br><i>Baltimore, Md</i>   |                                  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME<br><i>Snoden Disney</i>   |                                  | 14. MOTHER'S MAIDEN NAME<br><i>Amelia Belt</i>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown)   |                                  | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><i>Mrs. Fred Emmel, 2903 Shirley</i>   |                                  | ADDRESS   |  |

|   |   |  |
|---|---|--|
| 18. <i>420.0 I</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | CAUSE OF DEATH<br>(A) <i>arteriosclerotic Heart Disease</i><br>DUE TO <i>myocardial infarction</i><br>(B) <i>arteriosclerotic</i><br>DUE TO<br>(C) <i>Diabetes Mellitus</i> | INTERVAL BETWEEN ONSET AND DEATH<br><i>10 yrs.</i><br><i>15 yrs.</i><br><i>10 yrs.</i> |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |   |  |

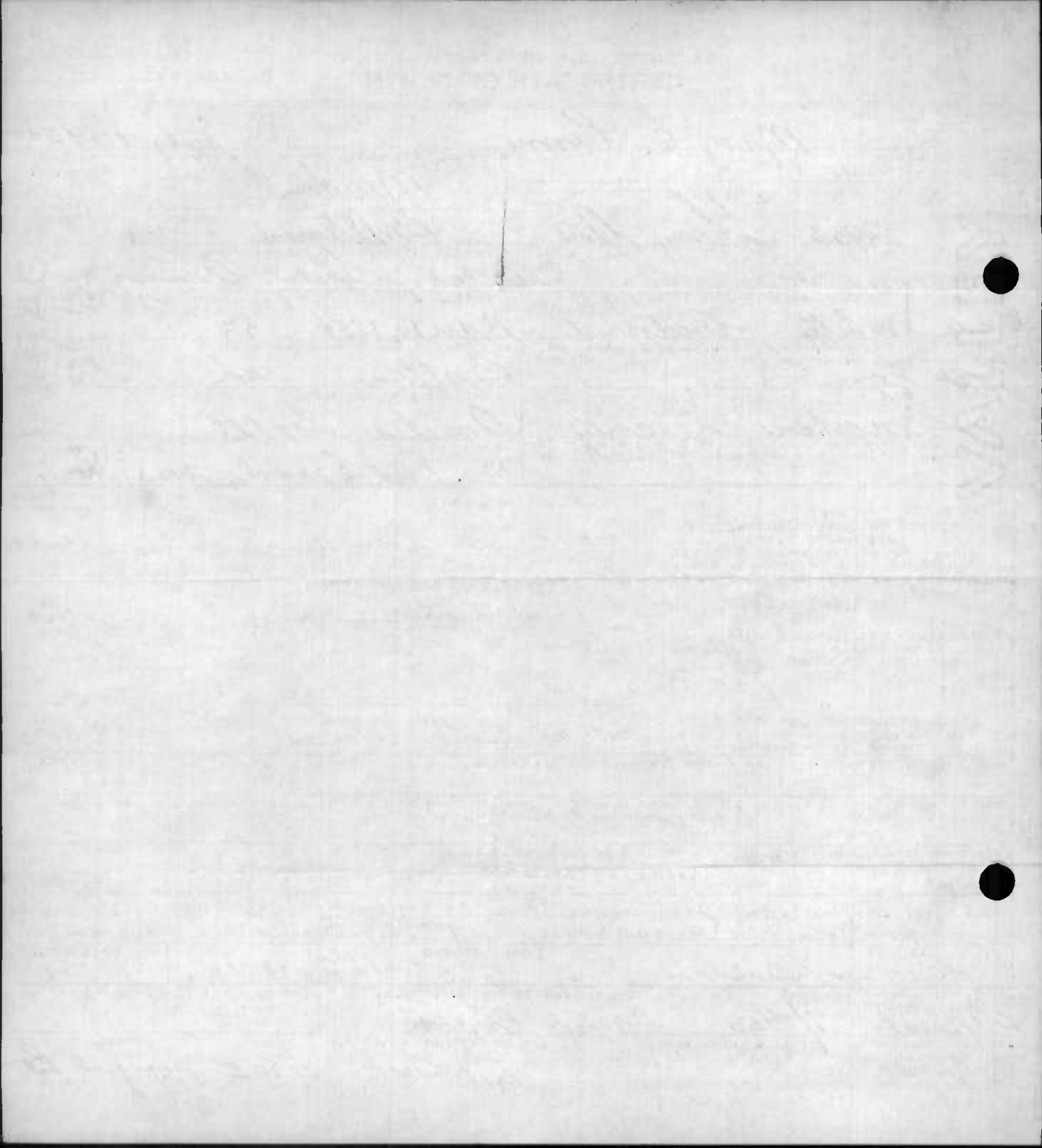
|  |   |   |
|--|---|---|
| 19A. DATE OF OPERATION<br><i>0</i>           | 19B. MAJOR FINDINGS OF OPERATION  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |

22. I hereby certify that I attended the deceased from *Jan 10, 1940* to *July 4, 1950*, that I last saw the deceased alive on *July 4, 1950*, and that death occurred at *4:30 p.m.*, from the causes and on the date stated above.

|  |   |                                   |
|--|---|-----------------------------------|
| 23A. SIGNATURE<br><i>Ernest Sawyer</i> | 23B. ADDRESS<br><i>4808 Harford Rd.</i> | 23C. DATE SIGNED<br><i>7/5/50</i> |
|--|---|-----------------------------------|

|  |                            |  |  |
|--|----------------------------|--|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i> | 24B. DATE<br><i>7/7/50</i> | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Camp Chapel</i> | 24D. LOCATION (City, town, or county) (State)<br><i>Maryland</i> |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUL 7 - 1950</i>    |                            | 25. FUNERAL DIRECTOR<br><i>L. Luck 5305 Harford Rd</i>   |  |





500

50 5964

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5964

BIRTH NO.

|  |                           |   |  |
|--|---------------------------|---|--|
| 1. NAME OF DECEASED<br>(Type or Print)   |                           | 2. DATE OF DEATH  |  |
| ANNA COHEN   |                           | July 6, 1950  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland 1727 N. Bentalou St                                    |                           | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland<br>B. COUNTY |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br>1727 N. Bentalou Street                                       |                           | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 15-03                         |  |
| D. STREET ADDRESS (If rural, give location)<br>1727 N. Bentalou Street                                   |                           | E. LENGTH OF STAY IN BALTIMORE<br>55 Yrs.   |  |
| 5. SEX<br>Female   | 6. COLOR OR RACE<br>White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>MARRIED  | 8. DATE OF BIRTH<br>1885               |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife |                           | 10B. KIND OF BUSINESS OR INDUSTRY<br>Own Home   | 9. AGE (In years: last birthday)<br>65 |
| 11. BIRTHPLACE (State or foreign country)<br>Russia  |                           | 12. CITIZEN OF WHAT COUNTRY?<br>USA.  |  |
| 13. FATHER'S NAME<br>Isaac Feinstein   |                           | 14. MOTHER'S MAIDEN NAME<br>Esther ?  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br>No                                  |                           | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br>Meyer Cohen-  |                           | ADDRESS<br>1727 N. Bentalou Street  |  |

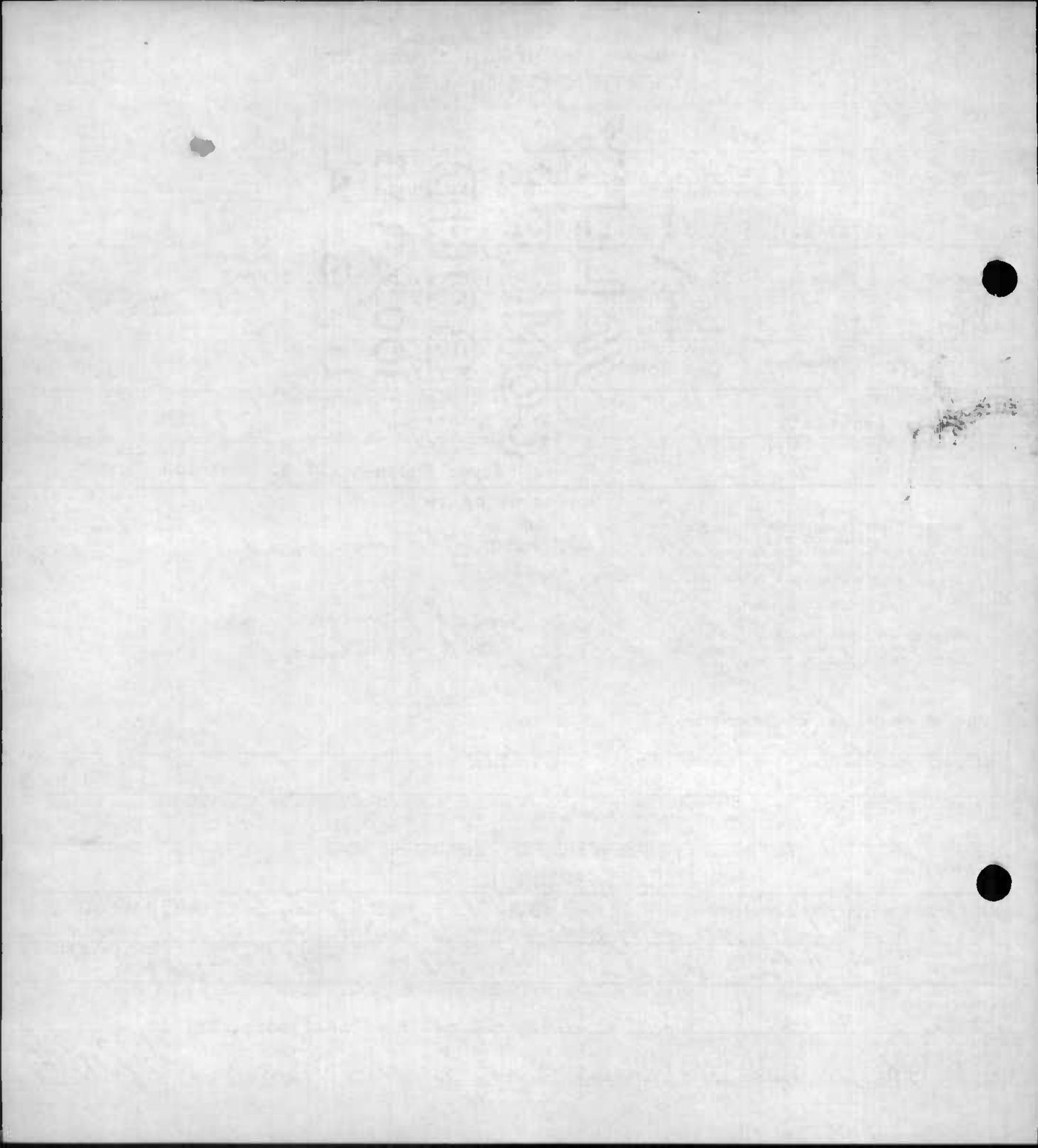
|  |
|--|
| 18. 331X I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br>A. Coar pneumonia<br>DUE TO<br>B. Cerebral hemorrhage and paralysis<br>DUE TO<br>C. ...<br>INTERVAL BETWEEN ONSET AND DEATH<br>about 2 days |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |

|   |   |   |
|---|---|---|
| 19A. DATE OF OPERATION                          | 19B. MAJOR FINDINGS OF OPERATION  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)      | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |

22. I hereby certify that I attended the deceased from Jan 1 1950, to July 6, 1950 that I last saw the deceased alive on July 6, 1950, and that death occurred at 6:00 pm., from the causes and on the date stated above.

|   |  |   |
|---|--|---|
| 23A. SIGNATURE<br>Benj. Hader                           | 23B. ADDRESS<br>2306 E. Bentalou St                          | 23C. DATE SIGNED<br>July 7-1950                                 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial     | 24B. DATE<br>7-7-50  | 24C. NAME OF CEMETERY OR CREMATORY<br>Tiferes Israel - Rosedale |
| 24D. LOCATION (City, town, or county)<br>Baltimore, Md. | 24E. FUNERAL DIRECTOR<br>Sol. Levinson + Bros. W. North Ave. |   |

|  |  |   |
|--|--|---|
| DATE RECEIVED BY LOCAL REGISTRAR<br>JUL 7-1950 | REGISTRAR'S SIGNATURE<br>Huntington Williams, M.D. | 25. FUNERAL DIRECTOR<br>Sol. Levinson + Bros. W. North Ave. |
|--|--|---|



12

50 5965

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 5965

1. NAME OF DECEASED (Type or Print) HONIE PHILLIPS

2. DATE OF DEATH July 5, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Balto. Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 17-01

D. STREET ADDRESS (If rural, give location) 556 W. Biddle St.

5. SEX F

6. COLOR OR RACE Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow

8. DATE OF BIRTH 29 May 1895

9. AGE (In years last birthday) 55

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife

10A. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Florida

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Walker

14. MOTHER'S MAIDEN NAME Emma Rappley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no

16. SOCIAL SECURITY NO. —

17. INFORMANT Mattie Lasker 556 Biddle St.

18. 260X I CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) uremia DUE TO

INTERVAL BETWEEN ONSET AND DEATH 1 wk.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) intercapillary glomerulosclerosis DUE TO

INTERVAL BETWEEN ONSET AND DEATH 12 yrs.

(C) diabetes mellitus DUE TO

INTERVAL BETWEEN ONSET AND DEATH 12 yrs.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION —

19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —

21D. TIME (Month) (Day) (Year) (Hour) INJURY —

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from July 5, 1950, to July 5, 1950, that I last saw the deceased alive on July 5, 1950, and that death occurred at 2:10 A.m., from the causes and on the date stated above.

23A. SIGNATURE Frank S. Kuehn M. D.

23B. ADDRESS Mercy Hospital

23C. DATE SIGNED July 5, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 7/10/50

24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary

24D. LOCATION (City, town, or county) (State) Cedar Hill Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 7 - 1950

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS W. Halstead - 918 - Shuid Hill Ave. 61

VS 150

RECEIVED  
FEBRUARY 19 1964



400

50 5966

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5966

|   |                                |  |   |  |   |
|---|--------------------------------|--|---|--|---|
| BIRTH NO.   |                                | 1. NAME OF DECEASED<br>(Type or Print) <b>HENRY NEAL</b>   |   | 2. DATE OF DEATH <b>July 4th, 1950</b>                                   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md</b><br>B. COUNTY |   |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>813 Asquith St</b>  |                                | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Balto.</b> <b>10-02</b>               |   |  |   |
| C. Length of stay in Baltimore <b>20yrs</b>   |                                | D. STREET ADDRESS (If rural, give location)<br><b>1224 Ashland Av</b>  |   |  |   |
| 5. SEX<br><b>M.</b>   | 6. COLOR OR RACE<br><b>Col</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>  | 8. DATE OF BIRTH<br><b>July 5th, 1894</b> | 9. AGE (In years last birthday)<br><b>55</b>                             | 10. Under 1 Year<br>Months: <b>11</b> Days: <b>29</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Barber</b>  |                                | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Hair Cutting</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>S.C.</b>                 |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                | 13. FATHER'S NAME<br><b>Henry Neal</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Agnes</b>                                 |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>No</b>  |                                | 16. SOCIAL SECURITY NO.<br><b>No</b>   |   | 17. INFORMANT (Cousin)<br><b>Mrs. Daniel Alston</b>                      |   |
| 18. <b>151X</b>   |                                | CAUSE OF DEATH   |   | INTERVAL BETWEEN ONSET AND DEATH   |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   |                                | (A) <b>Carcinoma of Stomach</b>  |   |  |   |
| DUE TO  |                                | (B)  |   |  |   |
| ANTECEDENT CAUSES   |                                | (C) <b>Secondary Anemia</b>  |   |  |   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |                                | (D)  |   |  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                                | (E)  |   |  |   |
| 19A. DATE OF OPERATION  |                                | 19B. MAJOR FINDINGS OF OPERATION   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  |                                | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                                |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |                                | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                |   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I hereby certify that I attended the deceased from <b>June 1948</b> to <b>June 27, 1950</b> , that I last saw the deceased alive on <b>June 27, 1950</b> , and that death occurred at <b>8<sup>00</sup> a. m.</b> , from the causes and on the date stated above. |                                |  |   |  |   |
| 23A. SIGNATURE<br><b>Morris A. Zini</b>   |                                | 23B. ADDRESS<br><b>118 Asquith St</b>  |   | 23C. DATE SIGNED<br><b>7/5/50</b>  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                | 24B. DATE<br><b>7/7/50</b>   |   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem.</b>             |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md</b>   |                                | 25. FUNERAL DIRECTOR<br><b>Chas. Swooper</b>   |   | ADDRESS<br><b>512 N. Carrollton Ave.</b>                                 |   |

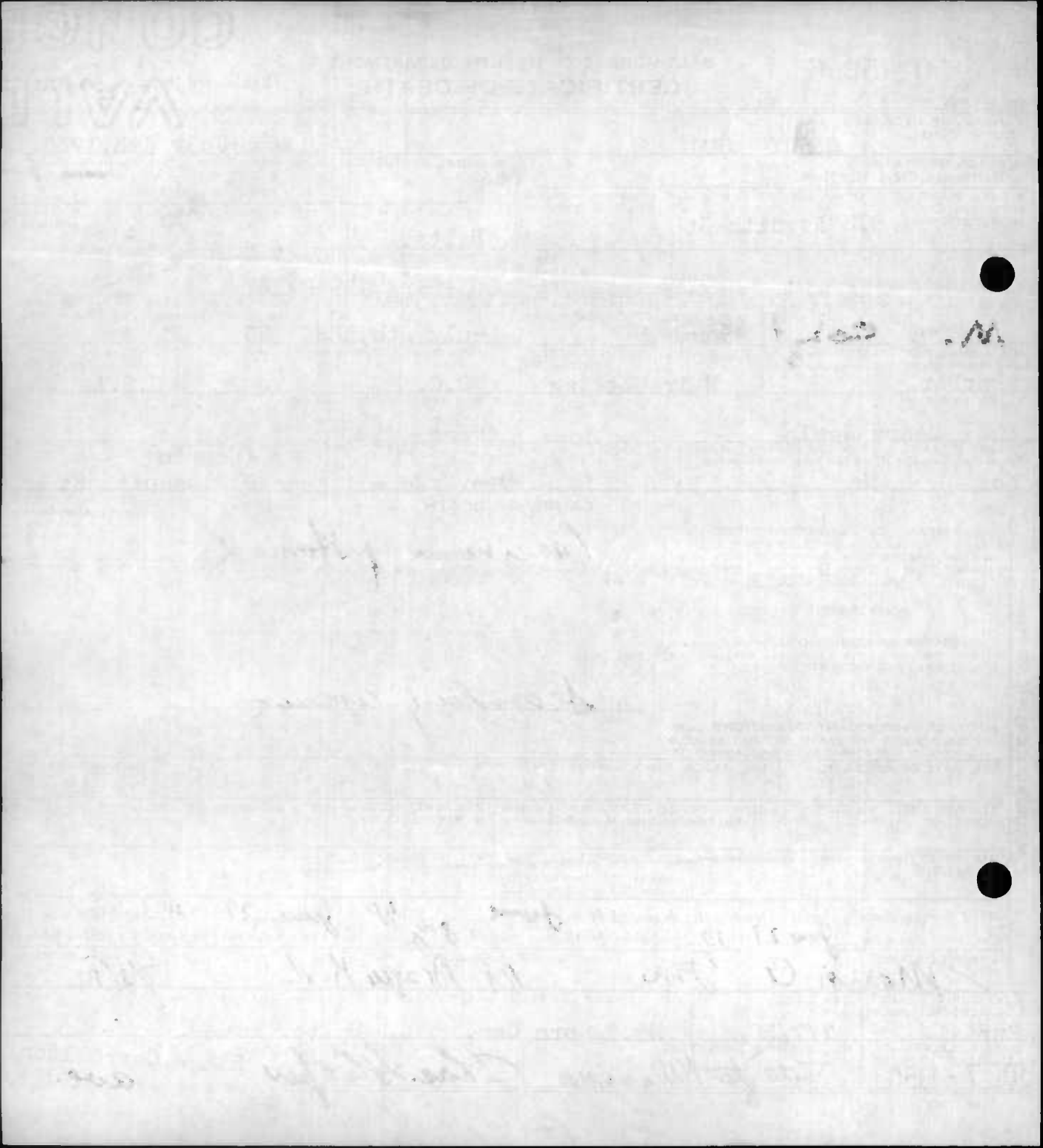
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46B

MEDICAL CERTIFICATION





363  
0 5967

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 5967

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) **CHARLES W. GODDARD** 2. DATE OF DEATH **7-6-50**

3. PLACE OF DEATH: A. Baltimore City, Maryland **1814 Morrell Park Ave** 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE **1814 Morrell Park Ave** B. COUNTY \_\_\_\_\_

B. FULL NAME OF HOSPITAL OR INSTITUTION **Ballo, Md** C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore Md.**

D. STREET ADDRESS (If rural, give location) **25-52**

C. Length of stay in Baltimore **25** Yrs. **25** Mos. **52** Days

5. SEX **M** 6. COLOR OR RACE **W** 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) \_\_\_\_\_ 8. DATE OF BIRTH **Feb 13, 1910** 9. AGE (In years last birthday) **40** 10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Roofers** 10B. KIND OF BUSINESS OR INDUSTRY \_\_\_\_\_ 11. BIRTHPLACE (State or foreign country) **A. Mary's City, Md.** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Rhoda Goddard** 14. MOTHER'S MILDEN NAME **Elizabeth Norris**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) **No** 16. SOCIAL SECURITY NO. \_\_\_\_\_ 17. INFORMANT **Stanley Goddard** ADDRESS **1814 Morrell Park Ave**

18. **163X** CAUSE OF DEATH **Carcinoma of Lung** INTERVAL BETWEEN ONSET AND DEATH **6 months**

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) **(A) DUE TO**

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. **(B) DUE TO**

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONCOITION CAUSING IT. **(C)**

19A. DATE OF OPERATION **0** 19B. MAJOR FINDINGS OF OPERATION \_\_\_\_\_ 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) \_\_\_\_\_ 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) \_\_\_\_\_ 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) \_\_\_\_\_

21D. TIME (Month) (Day) (Year) (Hour) \_\_\_\_\_ 21E. INJURY OCCURRED \_\_\_\_\_ 21F. HOW DID INJURY OCCUR? \_\_\_\_\_

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **4-14**, 19**50**, to **7-6**, 19**50**, that I last saw the deceased alive on **7-5**, 19**50**, and that death occurred at **6:30 A.M.**, from the causes and on the date stated above.

23A. SIGNATURE **John P. Unluck, Jr.** M. D. 23B. ADDRESS **1227 Wash. Blvd** 23C. DATE SIGNED **7-6-50**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **July 8, 1950** 24C. NAME OF CEMETERY OR CREMATORY **Lorraine Park Cem.** 24D. LOCATION (City, town, or county) (State) **Windsor Mill Rd. Baltimore Md.**

DATE RECEIVED BY LOCAL REGISTRAR **JUL 7 - 1950** REGISTRAR'S SIGNATURE **Winston Williams, Md** 25. FUNERAL DIRECTOR **St. Mark Jr.** ADDRESS **1306 Homestead**

MEDICAL CERTIFICATION

WATER RIGHTS

*[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a series of lines of text, possibly a list or a set of records, organized in columns. Some words like "water", "right", and "section" are faintly visible.]*

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 5968**

BIRTH NO.

|  |  |  |  |
|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>FREDERICK LANG</b>   |  | 2. DATE OF DEATH <b>July 5, 1950</b>   |  |
| 3. PLACE OF DEATH:<br>a. <b>Baltimore City, Maryland</b>   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>a. STATE <b>Maryland</b><br>c. CITY OR TOWN <b>Baltimore</b> (If outside corporate limits, write RURAL and give township)<br>d. STREET ADDRESS (If rural, give location) <b>2136 Frederick Avenue</b> |  |
| b. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Agnes Hospital</b>  |  | 5. SEX <b>male</b> 6. COLOR OR RACE <b>white</b> 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>  |  |
| c. LENGTH OF STAY IN BALTIMORE <b>Life</b>   |  | 8. DATE OF BIRTH <b>DEC. 22-1885</b> 9. AGE (In years last birthday) <b>64</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bristle Mixer</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Pittsburgh Plate Glass Co.</b>  |  |
| 11. BIRTHPLACE (State or foreign country) <b>BALTIMORE - MD.</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME <b>John Lang.</b>  |  | 14. MOTHER'S MAIDEN NAME <b>Susian Snyder</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>no.</b>                                      |  | 16. SOCIAL SECURITY NO. <b>213-10-5487</b>   |  |
| 17. INFORMANT <b>Mrs. Milton Lang</b>  |  | ADDRESS <b>3907 W. Mulberry St.</b>  |  |

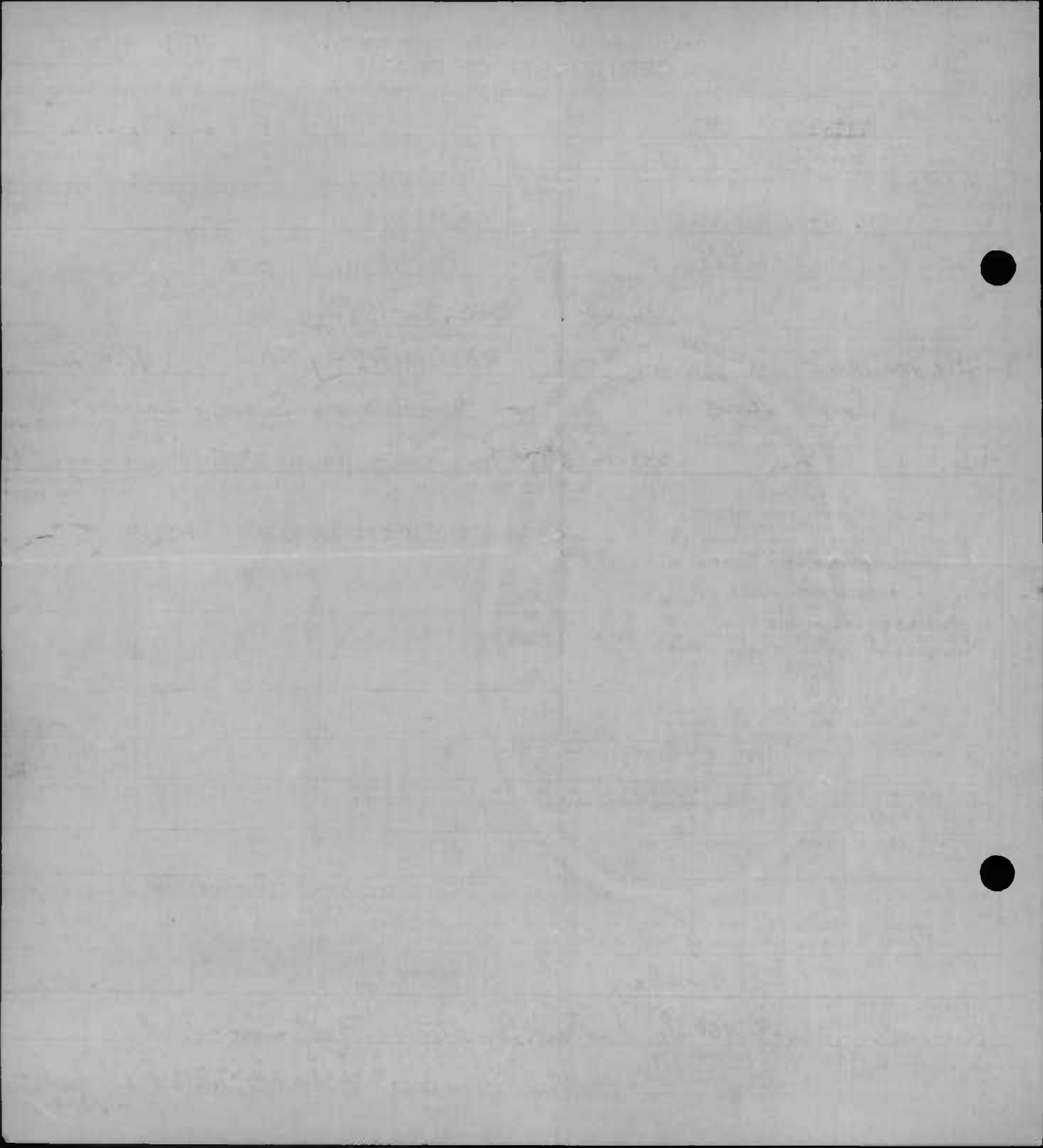
|  |  |                                  |
|--|--|----------------------------------|
| 18. <b>422.1</b> CAUSE OF DEATH  |  | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) |  |                                  |
| (A) <b>Arteriosclerotic cardiovascular disease</b>   |  |                                  |
| DUE TO   |  |                                  |
| ANTECEDENT CAUSES  |  |                                  |
| (B)  |  |                                  |
| DUE TO   |  |                                  |
| (C)  |  |                                  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |                                  |

|   |  |  |  |   |
|---|--|--|--|---|
| 19a. DATE OF OPERATION  |  | 19b. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR?  |

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

|  |  |   |  |  |
|--|--|---|--|--|
| 23a. SIGNATURE <b>R.S. Fisher</b>                            |  | 23b. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/> |  | 23c. DATE SIGNED <b>July 5, 1950</b>                           |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>      |  | 24b. DATE <b>July 8-1950</b>  |  | 24c. NAME OF CEMETERY OR CREMATORY <b>Louder Park Cemetery</b> |
| 24d. LOCATION (City, town, or county) <b>Baltimore - Md.</b> |  | (State)   |  |  |

|  |  |  |  |  |
|--|--|--|--|--|
| DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 7 1950</b> |  | REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b> |  | 25. FUNERAL DIRECTOR <b>Charles J. Schwalb</b> |
| ADDRESS <b>3512 Frederick -</b>                    |  |  |  |  |



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5969

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

PETER WAGNER

2. DATE OF DEATH July 5, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Franklin Square

Length of stay in Baltimore 65

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

O. STREET ADDRESS (If rural, give location)

3222 Belair Road

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

July 16, 1869

9. AGE (In years last birthday)

80

If Under 1 Year Months Days If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Butcher-retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Conrad Wagner

14. MOTHER'S MAIDEN NAME

Helen Blum

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

August C. Wagner 7806 Clarkworth Place

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Coronary occlusion

12 hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Hypertensive cardiac -

(C)

vascular disease

2 yrs.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., to or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb, 1948, to 7-5, 1950, that I last saw the deceased alive on 7-5, 1950, and that death occurred at 9:50 A. m., from the causes and on the date stated above.

23A. SIGNATURE

John Moore

M. O.

23B. ADDRESS

3105 Belair Rd

23C. DATE SIGNED

7-5-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

July 8, 1950

24C. NAME OF CEMETERY OR CREMATORY

Immanuel

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 7-1950

William Williams, M.D.

Ulrich Funeral Home 2008 Orleans St.

VS 150

937



NOT A MEDICAL EXAMINER'S CASE

*R. H. Fisher*

M.D.

CHIEF OR ASST. MEDICAL EXAMINER

50 5970

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5970  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Carrie R. Washington

2. DATE  
OF  
DEATH

July 4, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)A. STATE  
Baltimore

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

2213 W. Hamburg St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

25-03B

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

2213 W. Hamburg St.

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

April 16, 1875

9. AGE (In years  
last birthday)

75

If Under 1 Year  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John Wise

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.17. INFORMANT ADDRESS  
Mr. Ira Blocker 2407 Puget St.

18. 422.2

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) ...  
DUE TO

Chronic Myocarditis

4 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) ...  
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) ...

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK22. I hereby certify that I attended the deceased from Feb 10, 1946, to July 4, 1950, that I last saw the  
deceased alive on July 6, 1950, and that death occurred at 7:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

7-8-500

Mt. Auburn Cem

Baltimore

Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS 578 W.

JUL 7 - 1950

Huntington Williams, M.D.

Mrs. Frances A. Henry

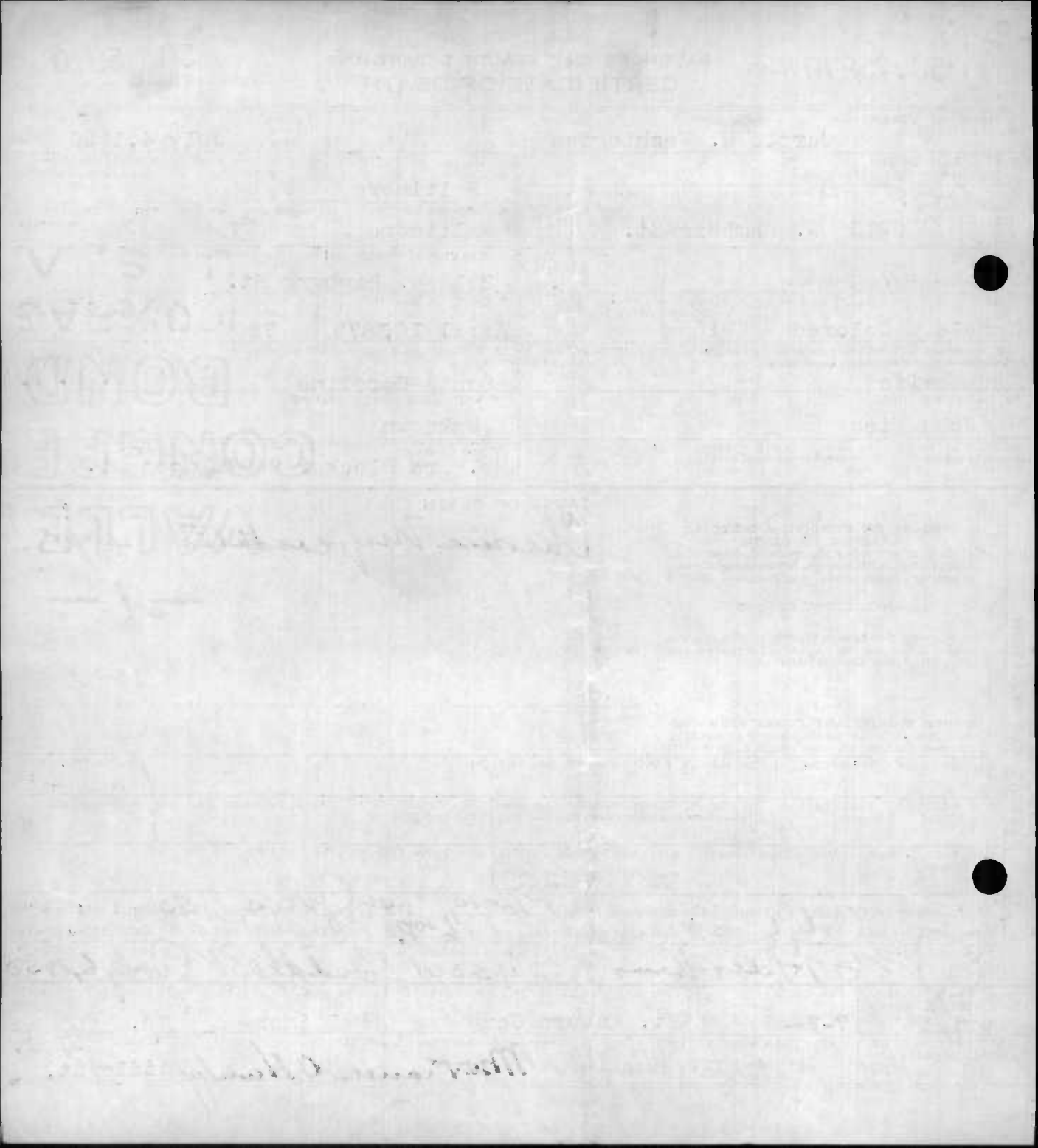
Biddle St.

VS 150

93D

15000005971

MEDICAL CERTIFICATION



663

50 5971

# MORIARTY

## BALTIMORE CITY HEALTH DEPARTMENT

### CERTIFICATE OF DEATH

50 5971 Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

RODERICK J. MORIARTY

2. DATE  
OF  
DEATH

July 7, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

S.B.G.H.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland Anne Arundel

C. CITY OR TOWN

H. outside corporate limits, write RURAL and give township)

Glen Burnie 5200

D. STREET ADDRESS (If rural, give location)

1429 Houghton St (Houghton Rd Harundale)

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

Dec 20-1901

9. AGE (In years  
last birthday)

48

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Unknown Clerk

10B. KIND OF BUSINESS OR  
INDUSTRY

Self

11. BIRTHPLACE (State or foreign country)

St Marys Kansas

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

WILLIAM J. MORIARTY

14. MOTHER'S MAIDEN NAME

ESTELLE WAFER

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

R.J. Moriarty, St Louis Mo

18. 420.1 I

CAUSE OF DEATH

INTERVAL, BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Coronary Occlusion

8 days

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

None

19B. MAJOR FINDINGS OF OPERATION

None

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JUNE 30, 1950, to JULY 7, 1950, that I last saw the  
deceased alive on JULY 6, 1950, and that death occurred at 1:25 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

W. J. Moriarty M. D.

S.B.G.H.

7/7/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 7-1950

Huntington Williams, Mo

1211 St Paul St

VS 150

39091

94a

MEDICAL CERTIFICATION



50 5972

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

442.7 50 5972  
Registered No. 50-5972

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>JOHN CALVIN BARNES</b>  |  |  | 2. DATE OF DEATH <b>July 3, 1950</b>  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <b>1409 W. Lafayette Ave</b>  |  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>Baltimore</b><br>C. CITY OR TOWN <b>16-02</b><br>D. STREET ADDRESS (If rural, give location) <b>1409 W. Lafayette Ave</b> |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>00 1409 W. Lafayette Ave.</b><br>C. Length of stay in Baltimore <b>65</b> |  |  | 5. SEX <b>male</b><br>6. COLOR OR RACE <b>Colored</b><br>7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>   |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>                 |  |  | 10B. KIND OF BUSINESS OR INDUSTRY <b>in hotel</b>   |  |  |
| 13. FATHER'S NAME <b>-</b>  |  |  | 14. MOTHER'S MAIDEN NAME <b>-</b>   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>-</b>   |  |  | 16. SOCIAL SECURITY NO. <b>212-07-9697</b>  |  |  |
| 17. INFORMANT <b>Mrs. Estella L. Barnes-1409 W. Lafayette Ave</b>   |  |  | ADDRESS <b>Lafayette Ave</b>  |  |  |

|   |  |  |
|---|--|--|
| 18. I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>C. Myocarditis</b><br>DUE TO |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>18 mos.</b> |
| II<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Nephritis</b><br>DUE TO   |  | <b>2 yrs.</b>                                      |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>Arteriosclerosis</b>  |  | <b>?</b>   |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 19A. DATE OF OPERATION <b>0</b>                 |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)      |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 22. I hereby certify that I attended the deceased from <b>1-14-</b> , 1950 to <b>7-3-</b> , 1950 that I last saw the deceased alive on <b>7-3-</b> , 1950 and that death occurred at <b>9:50 Pm.</b> , from the causes and on the date stated above. |  |  |  |   |  |
| 23A. SIGNATURE <b>John E. J. Campbell</b><br>M. D.   |  | 23B. ADDRESS <b>639 N. Carey St</b>                    |  | 23C. DATE SIGNED <b>7-3-50</b>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 24B. DATE <b>7-7-50</b>                                |  | 24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>                         |  |
| DATE RECEIVED BY LOCAL REGISTRAR <b>7-7-50</b>   |  | REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b> |  | 25. FUNERAL DIRECTOR <b>Holland Funeral Home</b><br>ADDRESS <b>1631 Druid Hill Ave.</b> |  |

MEDICAL CERTIFICATION



55

19

50 5973

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5973

BIRTH NO.

|  |                        |  |                                    |
|--|------------------------|--|------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) MISS FRANCES TAYLOR DAVIDSON  |                        | 2. DATE OF DEATH July 6, 1950  |                                    |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                        | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE Md.<br>B. COUNTY |                                    |
| B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION) 212 Stoney Run Lane Hillcrest Nursing Home |                        | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-02                       |                                    |
| C. Length of stay in Baltimore years Yrs. Mos. Days  |                        | D. STREET ADDRESS (If rural, give location) 3105 N. Calvert St.,   |                                    |
| 5. SEX Female  | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single   | 8. DATE OF BIRTH Aug. 1870         |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse (RN)   |                        | 10B. KIND OF BUSINESS OR INDUSTRY Nursing  | 9. AGE (In years last birthday) 79 |
| 11. BIRTHPLACE (State or foreign country) Lexington, Virginia  |                        | 12. CITIZEN OF WHAT COUNTRY? USA   |                                    |
| 13. FATHER'S NAME Col. Andrew Davidson   |                        | 14. MOTHER'S MAIDEN NAME Ann Logan   |                                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO  |                        | 16. SOCIAL SECURITY NO. NO   |                                    |
| 17. INFORMANT  |                        | ADDRESS Mr. John A. Johnston 103 W. 39th St. City  |                                    |

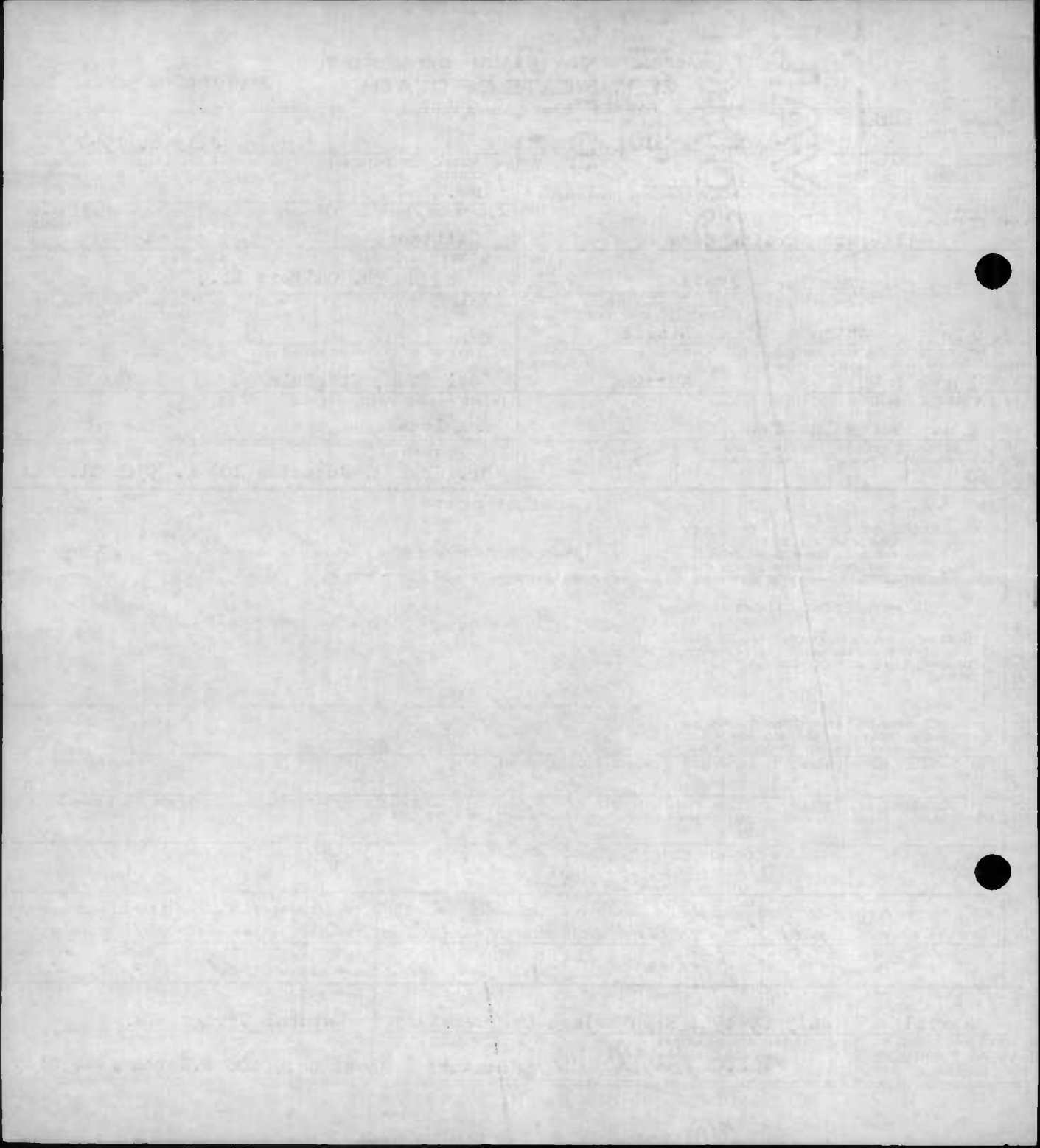
|   |   |   |
|---|---|---|
| 18. 422-1<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>DUE TO | CAUSE OF DEATH<br>(A) Arteriosclerotic Cardiovascular Disease | INTERVAL BETWEEN ONSET AND DEATH<br>2 yrs |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>DUE TO  | (B) Uncontrolled Arteriosclerosis                             | ?   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>DUE TO   | (C)   |   |

|  |   |   |
|--|---|---|
| 19A. DATE OF OPERATION 0                     | 19B. MAJOR FINDINGS OF OPERATION  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |

22. I hereby certify that I attended the deceased from June 6, 1950, to July 6, 1950, that I last saw the deceased alive on July 5, 1950, and that death occurred at 7:45 a.m., from the causes and on the date stated above.

|                                     |                                    |                            |
|-------------------------------------|------------------------------------|----------------------------|
| 23A. SIGNATURE<br>M. D. M. Williams | 23B. ADDRESS<br>20 E. Park Lane St | 23C. DATE SIGNED<br>7/7/50 |
|-------------------------------------|------------------------------------|----------------------------|

|  |  |   |   |
|--|--|---|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE July 8, 1950                             | 24C. NAME OF CEMETERY OR CREMATORY High Bridge Ch. Cemetery | 24D. LOCATION (City, town, or county) (State) Natural Bridge, Va. |
| DATE RECEIVED BY LOCAL REGISTRAR JUL 7 - 1950    | REGISTRAR'S SIGNATURE<br>Huntington Williams, M.D. | 25. FUNERAL DIRECTOR<br>Stewart & Mowen Co.,                | ADDRESS<br>108 W. North Ave., City                                |



50 5974

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5974  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)*Edwin Bull*2. DATE  
OF  
DEATH

July 6, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

*Md.*B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)*1026 Whitmore Ave.*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Baltimore**16-05*

D. STREET ADDRESS (If rural, give location)

*1026 Whitmore Ave.*

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

*male*

6. COLOR OR RACE

*white*7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)*married*

8. DATE OF BIRTH

*May 17, 1877*9. AGE (In years  
last birthday)*73*If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)*Carpenter*10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

*Maryland*12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

*Tego Bull*

14. MOTHER'S MAIDEN NAME

*Martha Tracy*15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)*no*16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

*Mrs. Mary Bull - 1026 Whitmore Ave.*18. *420 I*

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *June*, 19*49*, to *July 6*, 19*50*, that I last saw the  
deceased alive on *July 6*, 19*50*, and that death occurred at *9:35* a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

*2950 Edmondson Ave**7/6/50*24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)*Burial*

24B. DATE

*7/10/50*

24C. NAME OF CEMETERY OR CREMATORY

*Meadowridge Cem.*

24D. LOCATION (City, town, or county)

*Howard Co., Md.*

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*JUL 7 - 1950**H. H. Williams, M.D.**Wm. J. Tickner & Sons, Balto*

VS 150

51024

5

93D Md.

MEDICAL CERTIFICATION



163  
50 5975BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5975  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN C. NIPPARD

2. DATE  
OF  
DEATH

July 6, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE 1906 Chelsea Rd.4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE  
Md.C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Balto. 15-09D. STREET ADDRESS (If rural, give location)  
1906 Chelsea Rd.

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Feb. 12, 1906

9. AGE (in years  
last birthday)

44

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Freight Solicitor

10B. KIND OF BUSINESS OR  
INDUSTRY

Steamship

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Ringgold Nippard

14. MOTHER'S MAIDEN NAME

Fannie Hamilton

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.  
212-07-6282

17. INFORMANT

ADDRESS

Mrs. Dorothy R. Nippard 1906 Chelsea Rd.

18. 470.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Coronary occlusion

DUE TO

about  
15 min  
(from history)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Arterio-sclerosis

DUE TO

(C)

Hypertension

P

P

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr 30, 1947 to Apr 21, 1949 that I last saw the  
deceased alive on Apr 21, 1949 and that death occurred at 1229 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Walter S. Dubitt

M. D.

23B. ADDRESS

2220 Garrison Blvd

23C. DATE SIGNED

July 6/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/8/50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore Cem.

24D. LOCATION (City, town, or county) (State)

Balto., Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

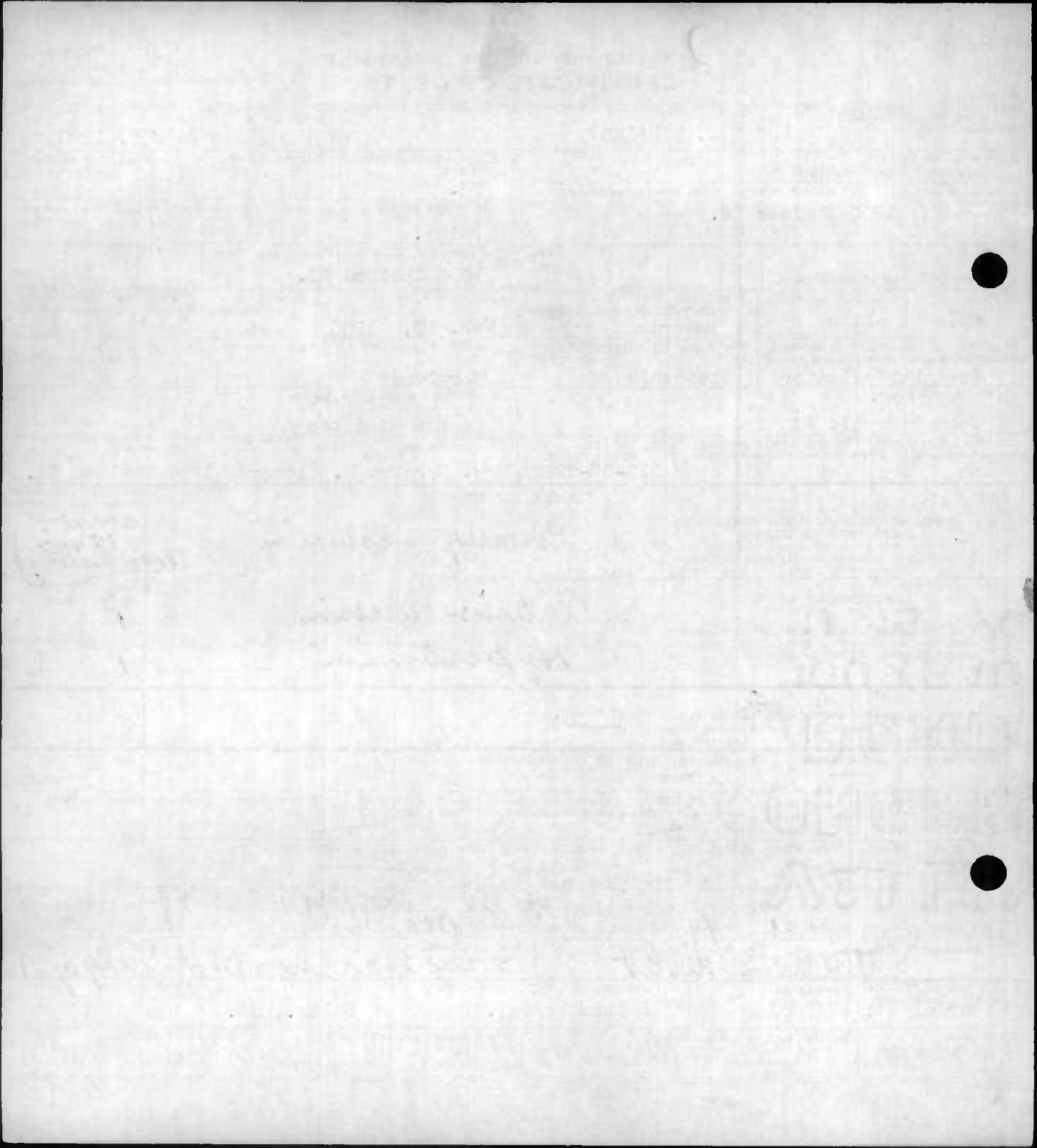
Wm. J. Dickner Sons Balto

VS 150

38055 5976

942 md.





-324

50 5976

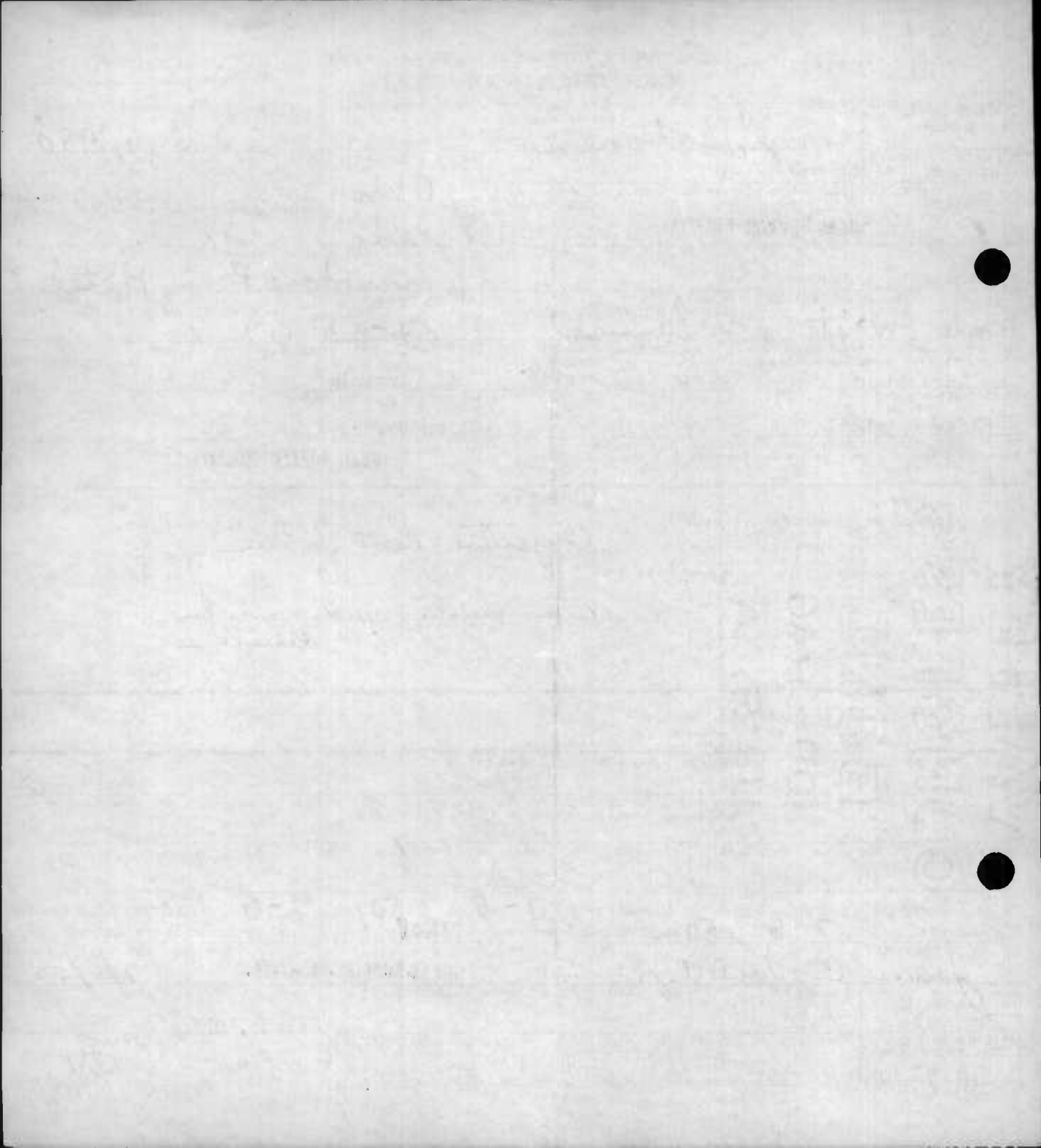
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5976  
Registered No.

|  |                                  |   |                                    |   |                              |
|--|----------------------------------|---|------------------------------------|---|------------------------------|
| BIRTH NO.  |                                  | 1. NAME OF DECEASED<br>(Type or Print) <i>George W. Batchell</i>  |                                    | 2. DATE OF DEATH <i>July 6, 1950</i>  |                              |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Ohio</i> B. COUNTY <i>V-32</i> |                                    |   |                              |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>JOHNS HOPKINS HOSPITAL</i>   |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Toledo</i>                                       |                                    |   |                              |
| 6. Length of stay in Baltimore   |                                  | D. STREET ADDRESS (If rural, give location)<br><i>Commodore Perry Hotel</i>   |                                    |   |                              |
| 5. SEX<br><i>Male</i>  | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Widowed</i>   | 8. DATE OF BIRTH<br><i>1-24-83</i> | 9. AGE (in years last birthday)<br><i>67</i>  | 10. Under 1 Year Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>President</i>  |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Toledo Engineering</i>  |                                    | 11. BIRTHPLACE (State or foreign country)<br><i>West Virginia</i>                   |                              |
| 12. CITIZEN OF WHAT COUNTRY?   |                                  | 13. FATHER'S NAME<br><i>Elmer Batchell</i>  |                                    |   |                              |
| 14. MOTHER'S MAIDEN NAME<br><i>Ellen Bowers</i>  |                                  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>no</i>               |                                    |   |                              |
| 16. SOCIAL SECURITY NO.  |                                  | 17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i> ADDRESS   |                                    |   |                              |
| 18. <i>4 yr. 1</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Congestive heart failure</i><br>DUE TO<br><i>Arteriosclerotic cardiovascular disease</i><br>DUE TO<br><i>diverse</i> |                                  | INTERVAL BETWEEN ONSET AND DEATH  |                                    |   |                              |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |                                  |   |                                    |   |                              |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                                  |   |                                    |   |                              |
| 19A. DATE OF OPERATION <i>0</i>  |                                  | 19B. MAJOR FINDINGS OF OPERATION  |                                    | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                              |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                                  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |                              |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                           |                                    | 21F. HOW DID INJURY OCCUR?  |                              |
| 22. I hereby certify that I attended the deceased from <i>7-5</i> , 19 <i>50</i> , to <i>7-6</i> , 19 <i>50</i> that I last saw the deceased alive on <i>7-6</i> , 19 <i>50</i> and that death occurred at <i>7208</i> m., from the causes and on the date stated above.   |                                  |   |                                    |   |                              |
| 23A. SIGNATURE<br><i>James C. Dardell Jr.</i><br>M. D.   |                                  | 23B. ADDRESS<br><i>JOHNS HOPKINS HOSPITAL</i>   |                                    | 23C. DATE SIGNED<br><i>7/6/50</i>   |                              |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Removal</i>  |                                  | 24B. DATE<br><i>7/7/50</i>  |                                    | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Toledo, Ohio</i>                           |                              |
| 24D. LOCATION (City, town, or county) (State)  |                                  | 24E. DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUL 7 - 1950</i>  |                                    | 24F. REGISTRAR'S SIGNATURE<br><i>Huntington Williams, M.D.</i>                      |                              |
| 24G. FUNERAL DIRECTOR<br><i>Wm. J. Dickner &amp; Sons</i>  |                                  | 24H. ADDRESS<br><i>Balto Md.</i>  |                                    | 24I. VS 150   |                              |

MEDICAL CERTIFICATION

290245 77 93D



100  
50 5977BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5977

BIRTH NO.

|  |                                  |   |   |  |   |
|--|----------------------------------|---|---|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>LAWRENCE VIRGIL SEIPP</b>  |                                  |   | 2. DATE OF DEATH<br><b>July 6, 1950</b>   |  |   |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b><br>B. COUNTY <b>9-06</b> |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>1818 E. 29th St.</b>   |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>                                      |  |   |
| C. Length of stay in Baltimore   |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>1818 E. 29th St.</b>  |  |   |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>widowed</b> | 8. DATE OF BIRTH<br><b>Aug. 17, 1876</b>  | 9. AGE (in years last birthday)<br><b>73</b> | If Under 1 Year<br>Months: Days<br>If Under 24 Hours<br>Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Street Car Conductor</b> |                                  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Transit</b>   |  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>  |                                  |   | 12. CITIZEN OF WHAT COUNTRY?  |  |   |
| 13. FATHER'S NAME<br><b>- Seipp</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                   |                                  |   | 16. SOCIAL SECURITY NO.   |  |   |
| 17. INFORMANT<br><b>Mr. Virgil Seipp</b>   |                                  |   | ADDRESS<br><b>1818 E. 29th St.</b>  |  |   |

|   |                                  |
|---|----------------------------------|
| 18. <b>4222</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Chronic Myocarditis</b><br>DUE TO<br>(A) .....<br>DUE TO<br>(B) .....<br>DUE TO<br>(C) ..... | INTERVAL BETWEEN ONSET AND DEATH |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                                  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 19A. DATE OF OPERATION<br><b>7/10/50</b>  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |  | 21E. INJURY OCCURRED<br>WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>June 27, 1950</b> , to <b>July 5, 1950</b> , that I last saw the deceased alive on <b>July 5, 1950</b> , and that death occurred at <b>m.</b> , from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE<br><b>Joseph J. Towhey</b>   |  | 23B. ADDRESS<br><b>444 S. Ellwood Ave.</b>  |  | 23C. DATE SIGNED<br><b>July 7-50</b>  |  |

|  |                             |   |  |
|--|-----------------------------|---|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24B. DATE<br><b>7/10/50</b> | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Cathedral Cem.</b> | 24D. LOCATION (City, town, or county) (State)<br><b>Balto., Md.</b>  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 7 - 1950</b>    |                             | REGISTRAR'S SIGNATURE<br><b>Wilmington Williams, M.D.</b>   | 25. FUNERAL DIRECTOR<br><b>Wm. J. Dickens &amp; Sons, Balto. Md.</b> |

63/51

93D

172

0104

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5978  
Registered No.

600  
5978  
BIRTH NO.

|   |                           |   |                                       |  |  |
|---|---------------------------|---|---------------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print)  |                           | WILLIAM J. BRAY   |                                       | 2. DATE OF DEATH<br>July 6, 1950   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                           |   |                                       | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE<br>Md.       |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTE<br>1301 Park Ave. |                           |   |                                       | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 11-02                |  |
| C. Length of stay in Baltimore  |                           |   |                                       | D. STREET ADDRESS (If rural, give location)<br>1206 St. Paul St.   |  |
| 5. SEX<br>male  | 6. COLOR OR RACE<br>white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br>single | 8. DATE OF BIRTH<br>March 15, 1879    |  |  |
|   |                           |   | 9. AGE (In years last birthday)<br>71 |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Draftsman                        |                           | 10B. KIND OF BUSINESS OR INDUSTRY<br>Caplan Bros.         |                                       | 11. BIRTHPLACE (State or foreign country)<br>England   |  |
| 12. CITIZEN OF WHAT COUNTRY?  |                           |   |                                       | 13. FATHER'S NAME<br>Unknown   |  |
| 14. MOTHER'S MAIDEN NAME<br>Unknown   |                           |   |                                       | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>No |  |
| 16. SOCIAL SECURITY NO.<br>215-03-1787  |                           |   |                                       | 17. INFORMANT ADDRESS<br>Mr. Carl L. Redd, 100 W. Monument St.   |  |

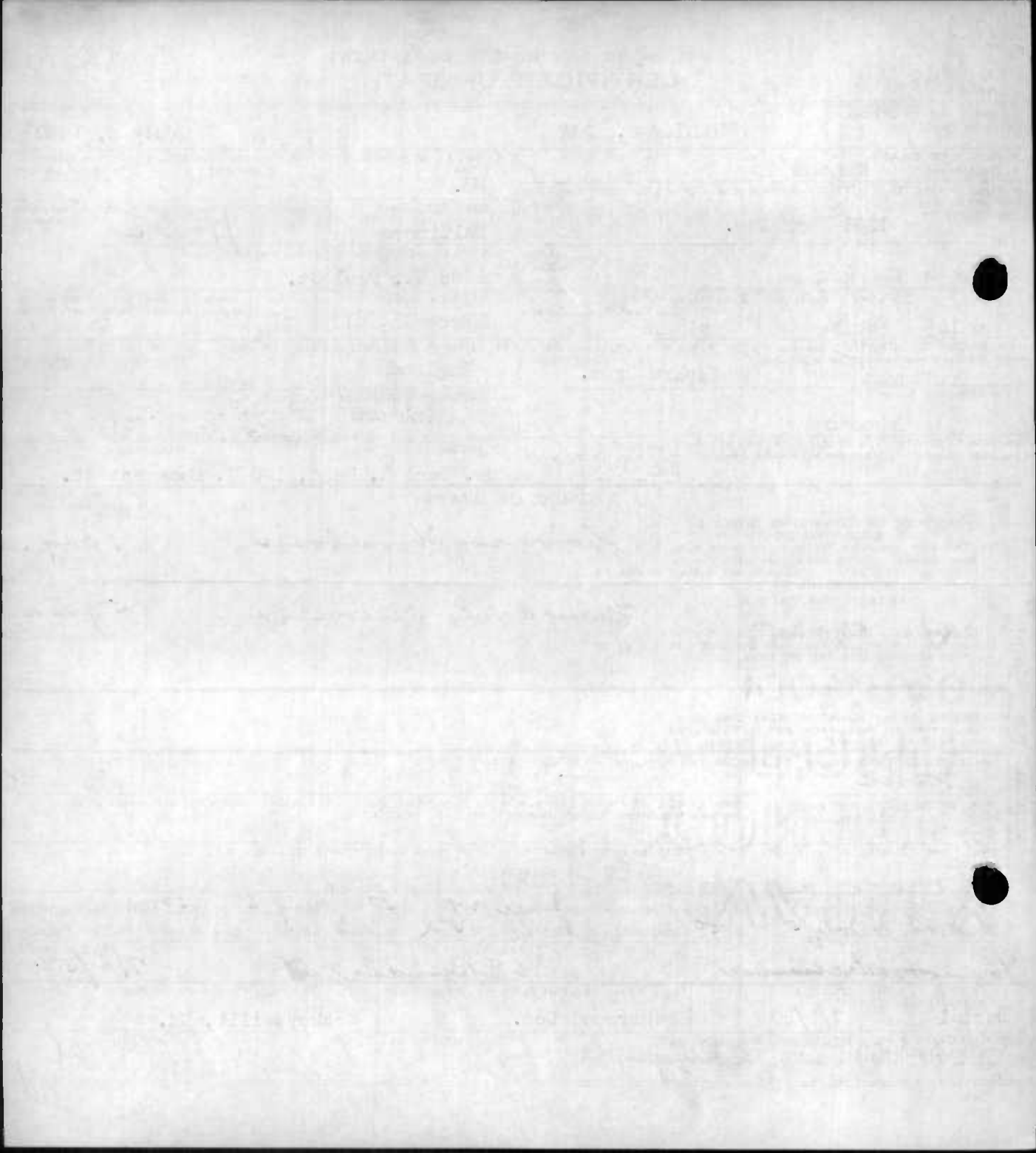
|  |  |  |  |   |
|--|--|--|--|---|
| 18. 470.1<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONOITION CAUSING IT. |  | CAUSE OF DEATH<br>(A) Secondary Thrombosis<br>DUE TO<br>(B) General Arterio-sclerosis<br>DUE TO<br>(C) |  | INTERVAL BETWEEN ONSET AND DEATH<br>1 day.<br>5 years |
|--|--|--|--|---|

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 19A. DATE OF OPERATION<br>None   |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDER-<br>LYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |  | 21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from June 29, 1950, to July 6, 1950, that I last saw the deceased alive on July 5, 1950, and that death occurred at 5A m., from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE<br>William F. Schellman   |  | 23B. ADDRESS<br>M. O. 6 E Biddle St   |  | 23C. DATE SIGNED<br>7/6/50  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 24B. DATE<br>7/7/50   |  | 24C. NAME OF CEMETERY OR CREMATORY<br>Sherwood Cem.                                 |  |
|  |  |   |  | 24D. LOCATION (City, town, or county) (State)<br>Cockeysville, Md.                  |  |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| DATE RECEIVED BY LOCAL REGISTRAR<br>JUL 7 1950 |  | REGISTRAR'S SIGNATURE<br>William F. Schellman |  | 25. FUNERAL DIRECTOR<br>Thos. J. Dickner & Sons |  |
|  |  |   |  | ADDRESS<br>Baltimore, Md.                       |  |

MEDICAL CERTIFICATION





500

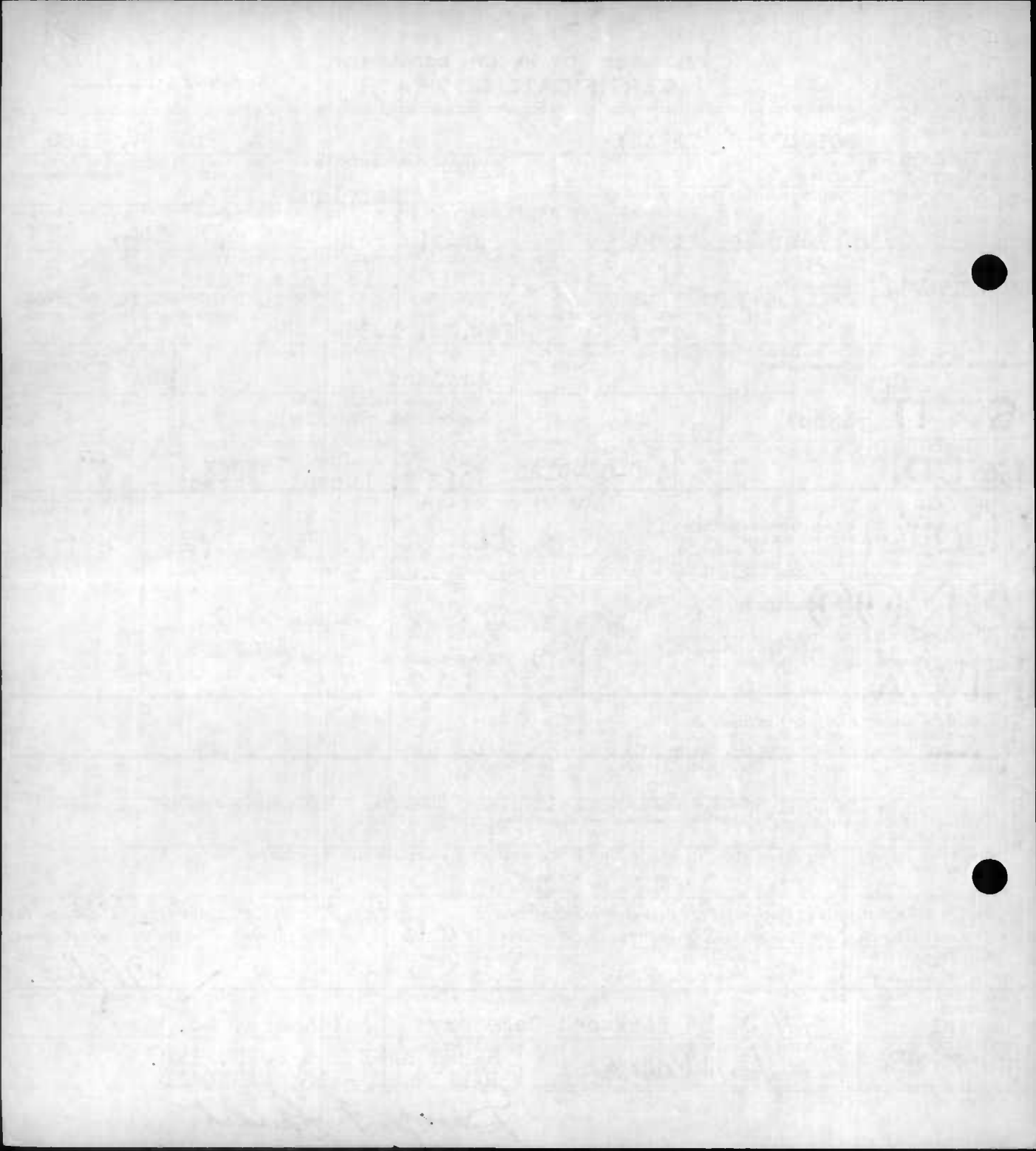
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5979

Registered No.

50 5979

|   |                           |  |  |
|---|---------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>SOLOMON F. TAWNEY</b>   |                           | 2. DATE OF DEATH <b>July 4, 1950</b>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                           | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>8-06</b> |  |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>2009 E. Lanvale Street</b>  |                           | C. CITY OR TOWN <b>Baltimore</b><br>D. STREET ADDRESS (If rural, give location) <b>2009 E. Lanvale Street</b>                              |  |
| 6. Length of stay in Baltimore<br>Yrs. <b>0</b><br>Mos. <b>0</b><br>Days <b>0</b>   |                           | 7. DATE OF BIRTH <b>Feb. 9, 1860</b>   |  |
| 8. SEX <b>M</b>   | 9. COLOR OR RACE <b>W</b> | 10. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widower</b>  | 11. AGE (In years last birthday) <b>90</b> |
| 12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>watchman</b>  |                           | 13. KIND OF BUSINESS OR INDUSTRY   |  |
| 14. FATHER'S NAME <b>Frederick Tawney</b>   |                           | 15. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |  |
| 16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>   |                           | 17. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |
| 18. SOCIAL SECURITY NO. <b>220-03-9122</b>  |                           | 19. MOTHER'S MAIDEN NAME <b>Rebecca Sherfey</b>  |  |
| 20. INFORMANT <b>Mr. Arthur W. Tawney</b>   |                           | 21. ADDRESS <b>2015 E. Lanvale Street - 13</b>   |  |
| 22. 442X<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cardio-renal-vascular disease</b>            |                           | 23. INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>   |  |
| 24. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Peripheral vascular disease</b>  |                           | 25. DUE TO <b>Dry gangrene great toe and 3rd toe 4 feet.</b>   |  |
| 26. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                           |  |  |
| 27. 19A. DATE OF OPERATION <b>0</b>   |                           | 28. 19B. MAJOR FINDINGS OF OPERATION   |  |
| 29. 20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |                           | 30. 20B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  |
| 31. 20C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                           | 32. 20D. TIME (Month) (Day) (Year) (Hour) INJURY   |  |
| 33. 20E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                           | 34. 20F. HOW DID INJURY OCCUR?   |  |
| 35. 22. I hereby certify that I attended the deceased from <b>Jan 1948</b> to <b>July 4, 1950</b> , that I last saw the deceased alive on <b>June 22, 1950</b> , and that death occurred at <b>10:45 p.m.</b> , from the causes and on the date stated above. |                           |  |  |
| 36. 23A. SIGNATURE <b>George A. Bowden</b>  |                           | 37. 23B. ADDRESS <b>323 Med. Art Bldg</b>  |  |
| 38. 23C. DATE SIGNED <b>7/7/50</b>  |                           | 39. 24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>  |  |
| 40. 24B. DATE <b>7/7/50</b>   |                           | 41. 24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>  |  |
| 42. 24D. LOCATION (City, town, or county) <b>Baltimore, Md.</b>   |                           | 43. 24E. DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 7 1950</b>  |  |
| 44. REGISTRAR'S SIGNATURE <b>Wm. J. Williams, M.D.</b>  |                           | 45. 25. FUNERAL DIRECTOR <b>HENRY SANDER &amp; SONS, INC.</b>  |  |
| 46. ADDRESS <b>BALTIMORE - 13, MARYLAND</b>   |                           | 47. SIGNATURE <b>George F. Sander</b>  |  |



200  
50 5980Tighe  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5980

|  |                           |  |                                      |   |   |
|--|---------------------------|--|--------------------------------------|---|---|
| BIRTH NO.  |                           | 1. NAME OF DECEASED<br>(Type or Print) <i>Thomas Tighe</i>   |                                      | 2. DATE OF DEATH <i>July 6 / 50</i>   |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>Baltimore</i>   |                           | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <i>MD.</i> B. COUNTY <i>9-08</i> |                                      |   |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Little Sisters of the Poor Home for the Aged</i>                |                           | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>BALTO.</i>   |                                      |   |   |
| C. Length of stay in Baltimore   |                           | D. STREET ADDRESS (If rural, give location) <i>2013 HOMEROD AVE</i>  |                                      |   |   |
| 5. SEX <i>m.</i>   | 6. COLOR OR RACE <i>W</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>SINGLE</i>  | 8. DATE OF BIRTH <i>Jan. 2, 1861</i> | 9. AGE (In years last birthday) <i>89</i>                                     | 10. Under 1 Year Months: Days Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i> |                           | 10B. KIND OF BUSINESS OR INDUSTRY <i>Title Searcher</i>  |                                      | 11. BIRTHPLACE (State or foreign country) <i>(?) MD.</i>                      |   |
| 13. FATHER'S NAME <i>John Tighe</i>  |                           | 14. MOTHER'S MAIDEN NAME <i>Bridget Burns</i>  |                                      |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>—</i>                                 |                           | 16. SOCIAL SECURITY NO. <i>—</i>   |                                      | 17. INFORMANT <i>Little Sisters of the Poor</i> ADDRESS <i>1200 Guffy St.</i> |   |

|  |   |
|--|---|
| 18. <i>422.1</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>DUE TO (A) <i>Chronic Myocarditis</i><br><br>ANTECEDENT CAUSES<br><br>DUE TO (B) <i>Arterio Sclerosis</i><br><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>DUE TO (C) <i>—</i> | INTERVAL BETWEEN ONSET AND DEATH<br><br><i>3 yrs</i><br><br><i>10 yrs</i> |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |   |

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|--|--|---|--|--|--|
| 19A. DATE OF OPERATION <i>0</i>  |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)         |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <i>July 2</i> , 1950, to <i>July 6</i> , 1950, that I last saw the deceased alive on <i>July 2</i> , 1950, and that death occurred at <i>6:40 am.</i> , from the causes and on the date stated above. |  |   |  |  |  |
| 23A. SIGNATURE <i>E. G. Hall</i>   |  | 23B. ADDRESS <i>1631 E North Ave</i>  |  | 23C. DATE SIGNED <i>July 6 1950</i>  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>  |  | 24B. DATE <i>7-8-50</i>   |  | 24C. NAME OF CEMETERY OR CREMATORY <i>CATHEDRAL - CITY</i>                       |  |
| DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 7 1950</i>   |  | REGISTRAR'S SIGNATURE <i>Huntington Williams</i>  |  | 25. FUNERAL DIRECTOR <i>Needlefield &amp; Son</i> ADDRESS <i>Spedmore + 22nd</i> |  |

91  
Q. M. Brown  
March 17, 1906

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5981  
Registered No.

BIRTH NO.

|   |  |   |  |
|---|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Flaharty, Frank</b>                   |  | 2. DATE OF DEATH<br><b>July 7, 1950</b>   |  |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>                        |  | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <b>Pg</b> B. COUNTY <b>York</b> |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hospital of Baltimore, Inc</b> |  | C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)<br><b>Stewartstown, Maryland Pennsylvania</b>       |  |
| D. STREET ADDRESS (If rural, give location)                                     |  |   |  |

|   |                                  |   |   |   |  |   |
|---|----------------------------------|---|---|---|--|---|
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>married</b> | 8. DATE OF BIRTH<br><b>5/23/90</b>  | 9. AGE (In years: last birthday)<br><b>60</b> | 10. Under 1 Year<br>Months: <b>1</b> Days: <b>14</b>         | 11. Under 24 Hours<br>Hours: <b>14</b> Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>caretaker</b> |                                  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>American Telephone Co</b>                   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b> |   |
| 12. CITIZEN OF WHAT COUNTRY?  |                                  |   | 13. FATHER'S NAME<br><b>George Flaharty</b>   |   |  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Ella Fletcher</b>  |                                  |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) |   |  |   |
| 16. SOCIAL SECURITY NO.   |                                  |   | 17. INFORMANT ADDRESS<br><b>Mrs. Cora Flaharty Stewartstown Pa</b>                  |   |  |   |

|  |                |  |
|--|----------------|--|
| 18. <b>443X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Hypertensive Arteriosclerosis</b><br>DUE TO <b>Cardio-Vascular Disease</b> | CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH<br><b>6-27-50</b><br><b>To</b><br><b>7-7-50</b> |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Myocardial infarction</b><br>DUE TO   |                |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>Cardiac Failure</b><br>DUE TO  |                |  |

|   |  |   |
|---|--|---|
| 19A. DATE OF OPERATION<br><b>7/5/50</b>         | 19B. MAJOR FINDINGS OF OPERATION<br><b>lumbar sympathectomy</b>  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |

22. I hereby certify that I attended the deceased from **6/27, 1950** to **7/7, 1950** that I last saw the deceased alive on **7/7, 1950**, and that death occurred at **6 a.m.**, from the causes and on the date stated above.

|  |   |   |
|--|---|---|
| 23A. SIGNATURE<br><b>Elmer B. Bernhart M.D.</b>                                    | 23B. ADDRESS<br><b>Sinai Hospital</b>     | 23C. DATE SIGNED<br><b>7/7/50</b>                         |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Buried</b>                         | 24B. DATE<br><b>7-10-50</b>               | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Stewartstown</b> |
| 24D. LOCATION (City, town, or county) (State)<br><b>Stewartstown, York Co, Pa.</b> | 25. FUNERAL DIRECTOR<br><b>W. H. Webb</b> | DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 7 - 1950</b>   |

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MEDICAL CERTIFICATION



UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

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WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5982  
Registered No. \_\_\_\_\_

|   |  |         |  |   |  |                               |  |
|---|--|---------|--|---|--|-------------------------------|--|
| BIRTH NO. 50 5982 50-02132  |  | CECILIA |  | BETHEA  |  | 2. DATE OF DEATH July 6, 1950 |  |
| 1. NAME OF DECEASED (Type or Print)   |  |         |  | 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |  |                               |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION<br>Franklin Square Hospital |  |         |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland<br>C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-03<br>D. STREET ADDRESS (If rural, give location) 627 N. Mount Street |  |                               |  |
| 5. SEX Female   |  |         |  | 6. COLOR OR RACE Colored  |  |                               |  |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single  |  |         |  | 8. DATE OF BIRTH 7-2-50   |  |                               |  |
| 9. AGE (In years last birthday) 5   |  |         |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant   |  |                               |  |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland   |  |         |  | 12. CITIZEN OF WHAT COUNTRY? USA  |  |                               |  |
| 13. FATHER'S NAME Carl Bethea   |  |         |  | 14. MOTHER'S MAIDEN NAME Delores Gant   |  |                               |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no  |  |         |  | 16. SOCIAL SECURITY NO.   |  |                               |  |
| 17. INFORMANT Carl Bethea   |  |         |  | ADDRESS 627 N. Mount St.  |  |                               |  |

18. 33.1X CAUSE OF DEATH  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  
(A) Subdural hematoma  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 19A. DATE OF OPERATION  |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)         |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY   |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 23A. SIGNATURE RS Fisher                                 |  | 23B. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER MEDICAL INVESTIGATOR |  | 23C. DATE SIGNED 7-7-50                            |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial         |  | 24B. DATE 7/9/50  |  | 24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cem   |  |
| 24D. LOCATION (City, town, or county) Westport Baltimore |  | 24E. STATE (State) Md   |  | 25. FUNERAL DIRECTOR Metropolitan Funeral Home Inc |  |
| DATE RECEIVED BY LOCAL REGISTRAR JUL 7 - 1950            |  | REGISTRAR'S SIGNATURE Huntington Williams, M.D.                             |  | ADDRESS  |  |

" " "  
John said this is all.

300  
5983Dowdy  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 5983  
Registered No.

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Oscar C. Dowdy</i>   |                                  | 2. DATE OF DEATH<br><i>7/6/50</i>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>Maryland General Hospital</i>   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>STATE <i>Maryland</i> B. COUNTY <i>13-05</i> |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>Maryland General Hospital</i>  |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)<br><i>Baltimore, Maryland</i>                           |  |
| C. Length of stay in Baltimore<br><i>Life</i>  |                                  | D. STREET ADDRESS (If rural, give location)<br><i>519 W 33rd Street #11</i>   |  |
| 5. SEX<br><i>male</i>  | 6. COLOR OR RACE<br><i>white</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>married</i>   | 8. DATE OF BIRTH<br><i>8/7/86</i>            |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>silver polisher</i>  |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>factory</i>   | 9. AGE (in years last birthday)<br><i>63</i> |
| 11. BIRTHPLACE (State or foreign country)<br><i>Virginia</i>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>   |  |
| 13. FATHER'S NAME<br><i>John Dowdy</i>   |                                  | 14. MOTHER'S MAIDEN NAME<br><i>Emma Payne</i>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)<br><i>No</i>  |                                  | 16. SOCIAL SECURITY NO.<br><i>213-10-3754</i>   | 17. INFORMANT<br><i>Lucille M. Dowdy</i>     |
| 18. <i>420.0</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>DUE TO<br>(A) <i>Myocardial infarct</i><br>(B) <i>Arteriosclerotic heart disease</i><br>(C) <i>Hypertensive cardiovascular disease</i> |                                  | ADDRESS<br><i>819 W. 33rd St</i>  |  |
| CAUSE OF DEATH   |                                  |   |  |
| INTERVAL BETWEEN ONSET AND DEATH   |                                  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                                  |   |  |
| 19A. DATE OF OPERATION<br><i>0</i>   |                                  | 19B. MAJOR FINDINGS OF OPERATION  |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br><input type="checkbox"/>  |                                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)  |                                  |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                             |  |
| 21F. HOW DID INJURY OCCUR?   |                                  |   |  |
| 22. I hereby certify that I attended the deceased from <i>7-4</i> , 19 <i>50</i> , to <i>7-6</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>7/6</i> , 19 <i>50</i> , and that death occurred at <i>2:19</i> m., from the causes and on the date stated above.   |                                  |   |  |
| 23A. SIGNATURE<br><i>Marguerite Louise Cadde</i>   |                                  | 23B. ADDRESS<br><i>Maryland General Hospital</i>  |  |
| 23C. DATE SIGNED<br><i>7/6/50</i>  |                                  |   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                                  | 24B. DATE<br><i>July 1950</i>   |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br><i>Holy Redeemer</i>   |                                  | 24D. LOCATION (City, town, or county) (State)<br><i>Belair Rd Md</i>  |  |
| 25. FUNERAL DIRECTOR<br><i>Justin E. Donovan</i>   |                                  | ADDRESS<br><i>3818 Belair Ave</i>   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUL 7 - 1950</i>  |                                  | REGISTRAR'S SIGNATURE<br><i>Huntington Williams</i>   |  |

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5984

|   |                                  |  |  |  |   |
|---|----------------------------------|--|--|--|---|
| BIRTH NO.   |                                  | 1. NAME OF DECEASED<br>(Type or Print)<br><b>Mrs. Martha Bowers</b>  |  | 2. DATE OF DEATH<br><b>July 6, 1950</b>                                    |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |  |  |   |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>St. Paul Convalescent Home</b><br><b>2305 St. Paul Street</b>   |                                  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b> <b>27-14</b>                  |  |  |   |
| C. Length of stay in Baltimore<br><b>50 years</b>   |                                  | D. STREET ADDRESS (If rural, give location)<br><b>4310 Evans Chapel Road</b>   |  |  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widow</b>  | 8. DATE OF BIRTH<br><b>Feb. 23, 1862</b> | 9. AGE (In years last birthday)<br><b>88</b>                               | 10. Under 1 Year<br>Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>At Home</b> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>               |   |
| 13. FATHER'S NAME<br><b>Wampler</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>                               |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>No</b>              |                                  | 16. SOCIAL SECURITY NO.<br><b>---</b>  |  | 17. INFORMANT ADDRESS<br><b>Charles M. Edrington 4310 Evans Chapel Rd.</b> |   |

|  |   |  |   |   |  |
|--|---|--|---|---|--|
| 18. <b>158X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Sarcoma, retroperitoneal 1 yr</b> |   | CAUSE OF DEATH   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>over</b>                                     |  |
| DUE TO   |   | (A)  |   |   |  |
| ANTECEDENT CAUSES  |   | (B)  |   |   |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |   | DUE TO   |   |   |  |
| (C)  |   |  |   |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |   |  |   |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>   |   | 19B. MAJOR FINDINGS OF OPERATION   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |   |   |  |
| 22. I hereby certify that I attended the deceased from <b>Jan 1950</b> to <b>July 6, 1950</b> , that I last saw the deceased alive on <b>July 6, 1950</b> and that death occurred at <b>5:00 p. m.</b> , from the causes and on the date stated above.   |   |  |   |   |  |
| 23A. SIGNATURE<br><b>E. Ellsworth Cook</b>   |   | 23B. ADDRESS<br><b>2431 Maryland Ave</b>                                 |   | 23C. DATE SIGNED<br><b>7-7-50</b>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 24B. DATE<br><b>July 8, 1950</b>  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn</b>                    | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Co., Maryland</b> |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 7 - 1950</b>  | REGISTRAR'S SIGNATURE<br><b>Thurston Williams, Md</b>   | 25. FUNERAL DIRECTOR<br><b>Burgee Funeral Home</b>                       |   | ADDRESS<br><b>3631 Falls Road</b>   |  |

MEDICAL CERTIFICATION

195000005085

46 H



Mr. G. G. Cook  
2431 Md. Ave.

Letter in document file 50-5984- 7/28/50.

246  
0 5985BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5985

1. NAME OF DECEASED  
(Type or Print)

LAWRENCE C. Eichler

2. DATE  
OF  
DEATH

7-7-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Union Memorial Hospital

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Texas

5200

D. STREET ADDRESS (If rural, give location)

- Church Lane

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

June 19, 1876

9. AGE (In years  
last birthday)

74

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Unioned from Pennsylvania RR.

10B. KIND OF BUSINESS OR  
INDUSTRY

Railroad

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John Eichler

14. MOTHER'S MAIDEN NAME

Elizabeth Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Hosp. Records

18. 420.0

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

DUE TO

(A) Acute coronary thrombosis

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B) Arteriosclerosis Heart disease

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Previous coronary thrombosis

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-6 1950, to 7-7 1950, that I last saw the  
deceased alive on 7-7 1950, and that death occurred at 5:15 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Francis A. Wall

23B. ADDRESS

M. D. Union Memorial Hosp.

23C. DATE SIGNED

7-7-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

7-9-50

24C. NAME OF CEMETERY OR CREMATORY

Sherwood

24D. LOCATION (City, town, or county)

Cockeysville, Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Sanderson M. Brooks, Sparks, Md

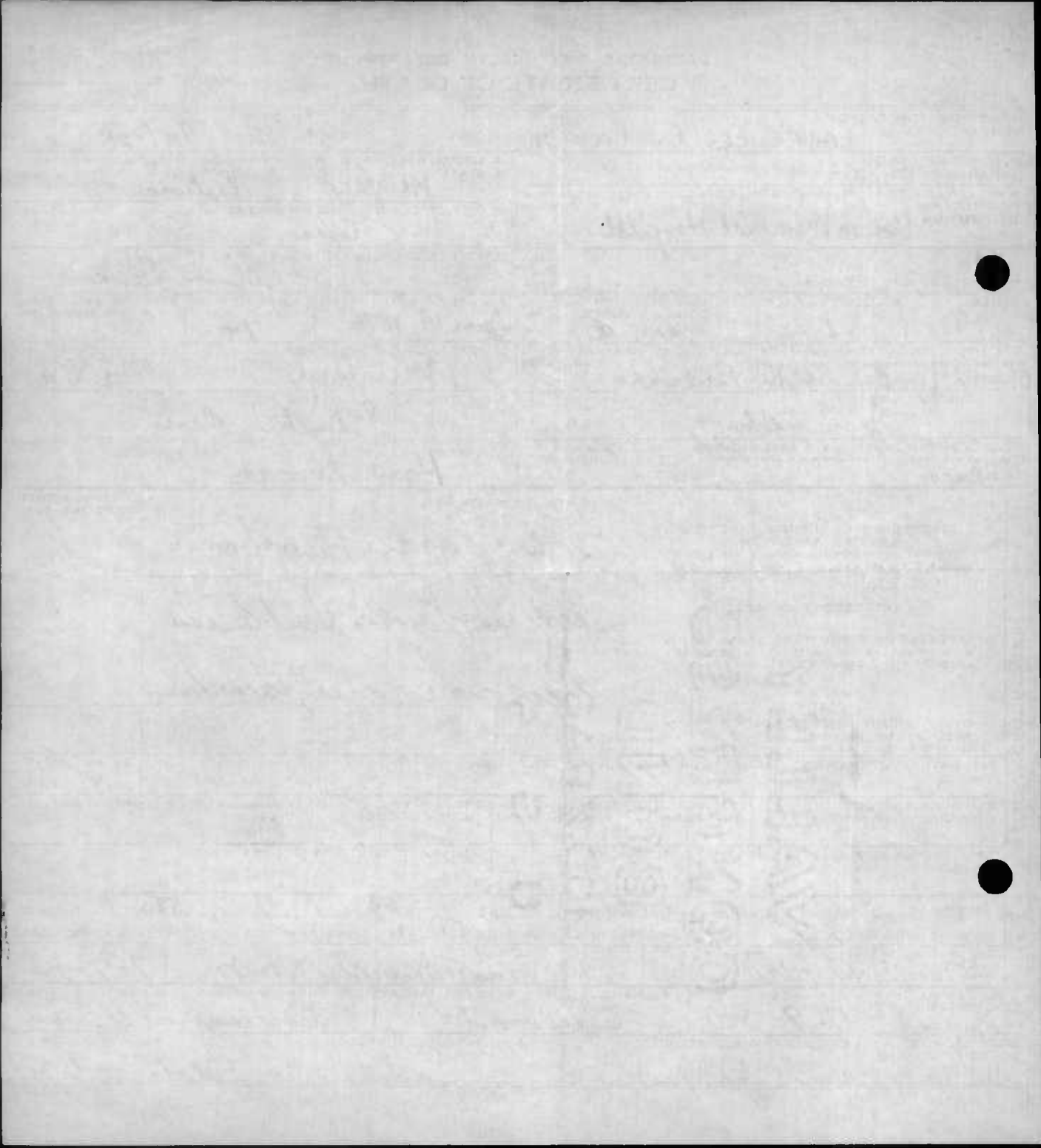
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93D

MEDICAL CERTIFICATION



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 5986  
Registered No.

BIRTH NO.

|   |                              |  |                                      |
|---|------------------------------|--|--------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Pauline K. Hill</i>                               |                              | 2. DATE OF DEATH<br><i>7/6/50</i>  |                                      |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                              | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE<br>B. COUNTY |                                      |
| B. FULL NAME OF HOSPITAL OR INSTITUTION<br><i>University Hospital</i>                       |                              | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Balto. Md. 23-01</i>        |                                      |
| C. Length of stay in Baltimore  |                              | D. STREET ADDRESS (If rural, give location)<br><i>112 Hammerbacker Court</i>                                   |                                      |
| 5. SEX<br><i>F</i>  | 6. COLOR OR RACE<br><i>C</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>married</i>  | 8. DATE OF BIRTH<br><i>11/9-1924</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |                              | 9. AGE (In years last birthday)<br><i>25 yrs.</i>  |                                      |
| 10B. KIND OF BUSINESS OR INDUSTRY   |                              | 11. BIRTHPLACE (State or foreign country)<br><i>N. Carolina</i>  |                                      |
| 13. FATHER'S NAME<br><i>Unknown</i>   |                              | 14. MOTHER'S MAIDEN NAME<br><i>Fannie J.</i>   |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)                           |                              | 16. SOCIAL SECURITY NO.  |                                      |
| 17. INFORMANT<br><i>Willard Hill</i>  |                              | ADDRESS<br><i>112 Hammerbacker</i>   |                                      |

|  |  |   |                                  |
|--|--|---|----------------------------------|
| 18. <i>490X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) |  | CAUSE OF DEATH<br>(A) <i>Bilateral lower lobe pneumonia</i> | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  | (B)   |                                  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  | (C)   |                                  |

CERTIFICATION APPROVED BY

CHIEF OR ASST. MEDICAL EXAMINER.

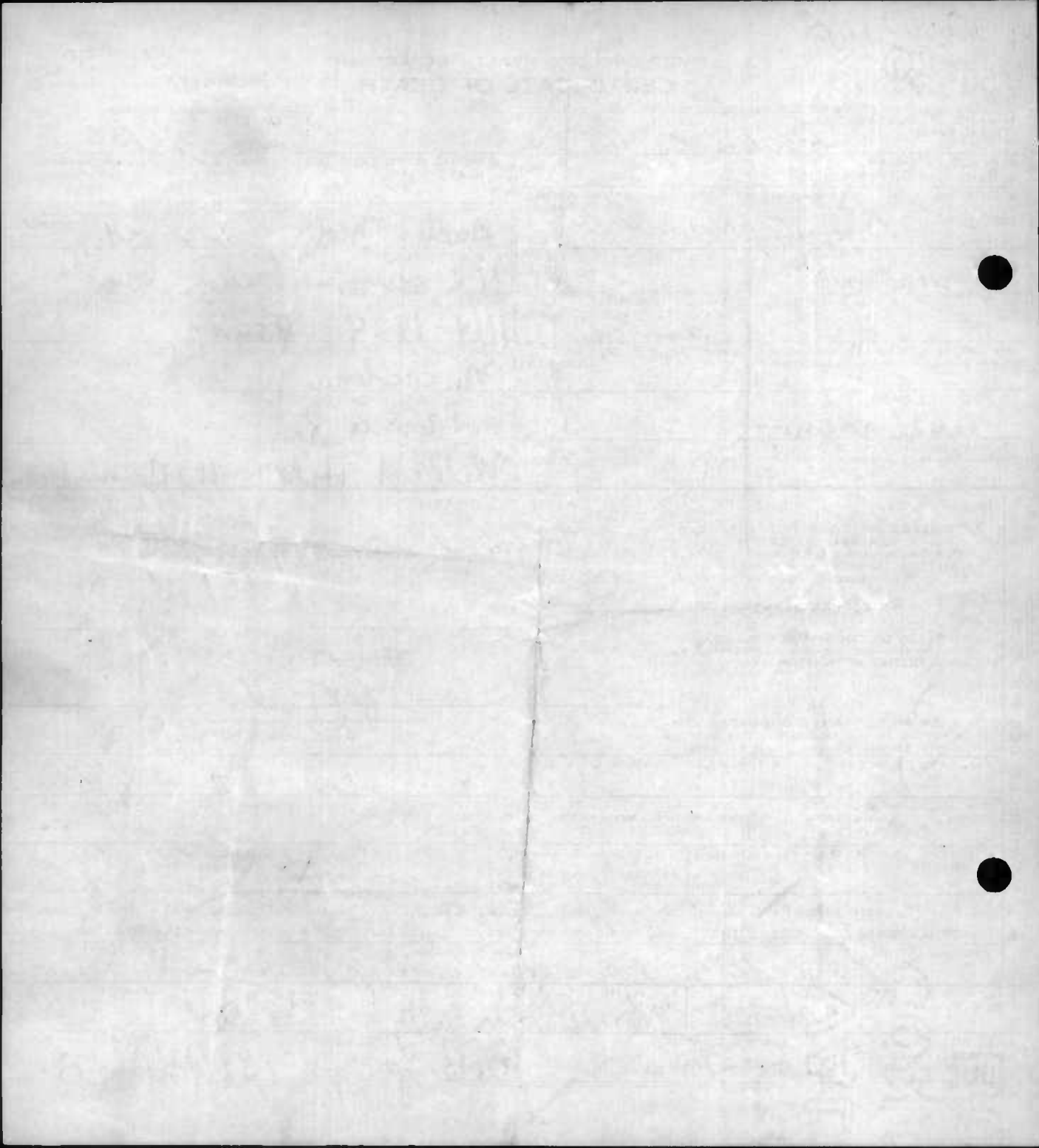
|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 19A. DATE OF OPERATION<br><i>7/6/50</i>         |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)      |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |

22. I hereby certify that I attended the deceased from *7/6/50*, 19*50*, to *7/6*, 19*50*, that I last saw the deceased alive on *7/6*, 19*50*, and that death occurred at *4 P. m.*, from the causes and on the date stated above.

|  |  |  |  |                                   |  |
|--|--|--|--|-----------------------------------|--|
| 23A. SIGNATURE<br><i>Ned C. McClintock</i> |  | 23B. ADDRESS<br><i>University Hospital</i> |  | 23C. DATE SIGNED<br><i>7/6/50</i> |  |
|--|--|--|--|-----------------------------------|--|

|   |  |                             |  |  |  |
|---|--|-----------------------------|--|--|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) |  | 24B. DATE<br><i>7-11-50</i> |  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Mt. Auburn Cemetery</i> |  |
|   |  |                             |  | 24D. LOCATION (City, town, or county) (State)<br><i>Balto.</i>   |  |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUL 7 - 1950</i> |  | REGISTRAR'S SIGNATURE<br><i>Wilmington Williams, M.D.</i> |  | 25. FUNERAL DIRECTOR<br><i>W. B. Spangis</i> |  |
|   |  |   |  | ADDRESS<br><i>139 W. Waverly St.</i>         |  |



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5987  
Registered No.

BIRTH NO.

|   |                                    |   |                                       |
|---|------------------------------------|---|---------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Thomas Samelton (Simaton)</b>   |                                    | 2. DATE OF DEATH<br><b>7-5-50</b>   |                                       |
| 3. PLACE OF DEATH:<br>a. Baltimore City, Maryland   |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>815 N. Central Avenue</b><br>b. COUNTY |                                       |
| b. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>Bar-Wil-Ba Convalescent Home</b> |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give town ship)<br><b>Baltimore, Maryland 10-02</b>                           |                                       |
| c. Length of stay in Baltimore <b>3 years</b>   |                                    | d. STREET ADDRESS (If rural, give location)   |                                       |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Colored</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>   | 8. DATE OF BIRTH<br><b>10-15-1881</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>               |                                    | 9. AGE (In years, Months, Days)<br><b>68</b>  |                                       |
| 10b. KIND OF BUSINESS OR INDUSTRY   |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>South Carolina</b>  |                                       |
| 13. FATHER'S NAME<br><b>Jessie Samelton</b>   |                                    | 12. CITIZEN OF WHAT COUNTRY?  |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                    |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Jessie Crosley</b>   |                                       |
| 16. SOCIAL SECURITY NO.<br><b>251-14-5756</b>   |                                    | 17. INFORMANT ADDRESS<br><b>Lucy Samelton-815 N. Central</b>  |                                       |

|  |   |  |
|--|---|--|
| 18. <b>422.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cardio Vascular Degeneration ?</b> |   | INTERVAL BETWEEN ONSET AND DEATH   |
| (A) DUE TO   |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |   |  |
| (B) DUE TO   |   |  |
| (C)  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |   |  |
| 19a. DATE OF OPERATION<br><b>0</b>   | 19b. MAJOR FINDINGS OF OPERATION  |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |  |
| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)   | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)       | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21e. INJURY OCCURRED<br>WHILE AT <input type="checkbox"/> WORK AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR?   |

22. I hereby certify that I attended the deceased from **June 27, 1950**, to **July 5, 1950**, that I last saw the deceased alive on **July 4, 1950**, and that death occurred at **12:02 P. M.** on the date stated above.

|  |  |   |
|--|--|---|
| 23a. SIGNATURE<br><b>H. K. Johnson</b>                     | 23b. ADDRESS<br><b>403 Weddell St</b>  | 23c. DATE SIGNED<br><b>July 5-50</b>                              |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24b. DATE<br><b>7/8/1950</b>   | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Calvary Em. R. P. Co</b> |
| 24d. LOCATION (City, town, or county) (State)<br><b>Md</b> | 25. FUNERAL DIRECTOR ADDRESS<br><b>Payner Sanders 930 97099 1412 E. Preston St</b> |   |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 7 - 1950</b>    |  |   |
| REGISTRAR'S SIGNATURE<br><b>Huntington Williams</b>        |  |   |

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MEDICAL CERTIFICATION



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CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOE L. SILVERSTEIN

2. DATE

OF DEATH JULY 7 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE WEST VIRGINIA

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

CHARLESTOWN

D. STREET ADDRESS (If rural, give location)

1618 HANAWHA BLVD; BOX 271

Length of stay in Baltimore

8

Yrs.  
Moe.  
Days

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

JUNE 18, 1898

9. AGE (In years last birthday)

52

10 Under 1 Year Months Days

11 Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LAWYER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Silverstein

ALEXANDER B. ROSEN (D)

14. MOTHER'S MAIDEN NAME

LENA ROSEN (L)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

UNKNOWN

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. 581.0 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

CIRRHOSIS OF LIVER

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

Gastro-Intestinal Hemorrhage  
ESOPHAGEAL Varices

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to JULY 7, 1950, that I last saw the deceased alive on JULY 7, 1950, and that death occurred at 6:17 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Richard Beach

M. D.

23B. ADDRESS

Union Memorial Hosp. 7/7/50

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

July 9/50

24C. NAME OF CEMETERY OR CREMATORY

Springhill Cemy -

24D. LOCATION (City, town, or county) (State)

Charlestown W Va

DATE RECEIVED BY LOCAL REGISTRAR

JUL 7 - 1950

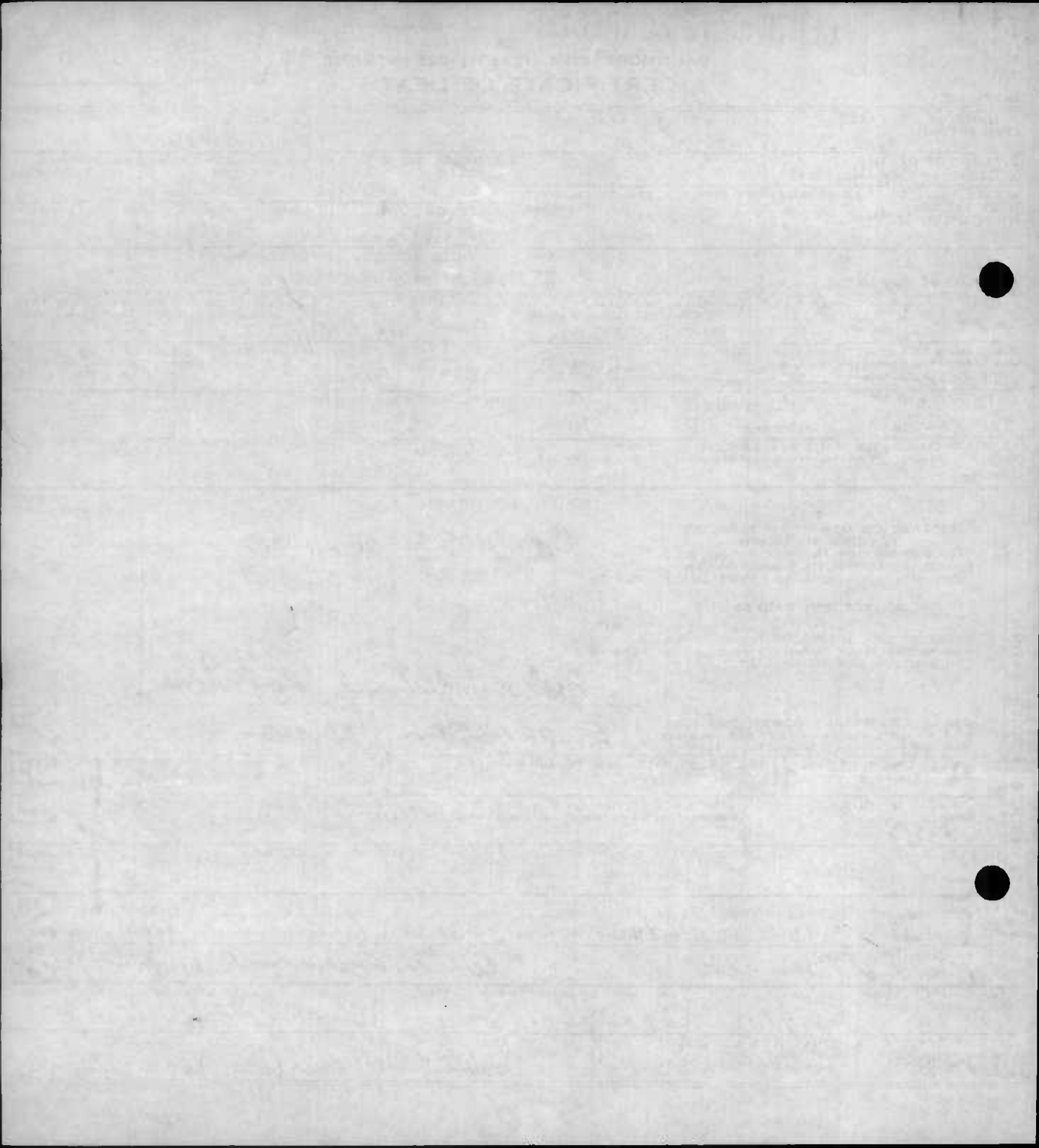
REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

David Soulehour 1802 Euter Rd

ADDRESS



621  
50 5989BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5989

BIRTH NO.

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>ALFREDO SARCHAPONE</b>  |  |  | 2. DATE OF DEATH <b>7-5-50.</b>  |  |  |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY |  |  |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION <b>Doctors Hospital</b> |  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 20-07</b>                         |  |  |
| D. STREET ADDRESS (If rural, give location)<br><b>409 Dennison St.</b>  |  |  | 5. SEX <b>M</b>  |  |  |
| 6. COLOR OR RACE <b>White</b>   |  |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>   |  |  |
| 8. DATE OF BIRTH <b>1885-9-16</b>   |  |  | 9. AGE (In years last birthday) <b>64 y.</b>   |  |  |
| 10A. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <b>Tailor</b>                                    |  |  | 10B. KIND OF BUSINESS OR INDUSTRY <b>Tailor</b>  |  |  |
| 11. BIRTHPLACE (State or foreign country) <b>Italy</b>  |  |  | 12. CITIZEN OF WHAT COUNTRY? <b>Italy</b>  |  |  |
| 13. FATHER'S NAME <b>Vincent Sarchapone</b>   |  |  | 14. MOTHER'S MAIDEN NAME <b>Josephine VILLAMAGNA</b>   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                |  |  | 16. SOCIAL SECURITY NO.  |  |  |
| 17. INFORMANT <b>Frank Sarchapone, (son)</b>  |  |  | ADDRESS <b>409 Dennison St.</b>  |  |  |

|  |  |  |   |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|
| 18. <b>561.0 1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Acute Coriary Sclerosis</b><br>DUE TO<br><b>Paralytic Cereus</b><br>DUE TO<br><b>Cerebral Arteriosclerosis (adverse)</b> |  |  | CAUSE OF DEATH<br><b>Acute Coriary Sclerosis</b><br><b>Paralytic Cereus</b><br><b>Cerebral Arteriosclerosis (adverse)</b> |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>30 hr</b><br><b>?</b>     |  |  |
| 19A. DATE OF OPERATION <b>7/4/50</b>   |  |  | 19B. MAJOR FINDINGS OF OPERATION <b>Left Encephaloma, resectable</b>  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   |  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                                 |  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)         |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  |  |  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                    |  |  | 21F. HOW DID INJURY OCCUR?   |  |  |
| 22. I hereby certify that I attended the deceased from <b>7/4</b> , 19 <b>50</b> , to <b>7/5</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>7/5</b> , 19 <b>50</b> , and that death occurred at <b>7:15 P. M.</b> , from the causes and on the date stated above.   |  |  |   |  |  |  |  |  |
| 23A. SIGNATURE <b>J. S. Sarchapone</b>   |  |  | 23B. ADDRESS <b>1901 E. St. City</b>  |  |  | 23C. DATE SIGNED <b>7/5/50</b>   |  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  |  | 24B. DATE <b>July 8 1950</b>  |  |  | 24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>                          |  |  |
| 24D. LOCATION (City, town, or county) (State) <b>Balt. Md</b>  |  |  | 24E. FUNERAL DIRECTOR <b>Frank Della Noce</b>   |  |  | 24F. ADDRESS <b>322 S. High St.</b>  |  |  |

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MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

11. Name of informant: [illegible]  
12. Address of informant: [illegible]  
13. Signature of informant: [illegible]  
14. Date of completion: [illegible]

235

50 5990

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5990

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ARTHUR WESTMORELAND

2. DATE

OF DEATH July 4, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

Johns Hopkins Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

727 N. Eden Street

Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

colored

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Unknown

9. AGE (In years

last birthday)

75?

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

laborer

10B. KIND OF BUSINESS OR INDUSTRY

Consolidated Construction Lawrence Co., S. Ca.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Lee Westmoreland

Co.

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

248-14-9611

17. INFORMANT

ADDRESS

Roy Westmoreland 1614 Milliman Street

18. 42.1

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

R. Fisher

M.D.

23B. CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

July 4, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify): shipment

24B. DATE

7/7/50

24C. NAME OF CEMETERY OR CREMATORY

Liberty Cemetery

24D. LOCATION (City, town, or county)

(State)

Spartansburg, South Carolina

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Trustington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Robert L. Young, 1532 E. Monument St.

JUL 7 - 1950

VS 151

97024

Robert L. Young

937

✓

MEDICAL CERTIFICATION



STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

|                                    |  |                                    |  |                                    |  |                                     |  |
|------------------------------------|--|------------------------------------|--|------------------------------------|--|-------------------------------------|--|
| 1. Name of deceased                |  | 2. Sex                             |  | 3. Age                             |  | 4. Date of death                    |  |
| 5. Place of death                  |  | 6. Cause of death                  |  | 7. Manner of death                 |  | 8. Signature of physician           |  |
| 9. Signature of registrar          |  | 10. Signature of informant         |  | 11. Signature of witness           |  | 12. Signature of coroner            |  |
| 13. Signature of funeral director  |  | 14. Signature of undertaker        |  | 15. Signature of cemetery          |  | 16. Signature of church             |  |
| 17. Signature of school            |  | 18. Signature of hospital          |  | 19. Signature of nursing home      |  | 20. Signature of other institution  |  |
| 21. Signature of other institution |  | 22. Signature of other institution |  | 23. Signature of other institution |  | 24. Signature of other institution  |  |
| 25. Signature of other institution |  | 26. Signature of other institution |  | 27. Signature of other institution |  | 28. Signature of other institution  |  |
| 29. Signature of other institution |  | 30. Signature of other institution |  | 31. Signature of other institution |  | 32. Signature of other institution  |  |
| 33. Signature of other institution |  | 34. Signature of other institution |  | 35. Signature of other institution |  | 36. Signature of other institution  |  |
| 37. Signature of other institution |  | 38. Signature of other institution |  | 39. Signature of other institution |  | 40. Signature of other institution  |  |
| 41. Signature of other institution |  | 42. Signature of other institution |  | 43. Signature of other institution |  | 44. Signature of other institution  |  |
| 45. Signature of other institution |  | 46. Signature of other institution |  | 47. Signature of other institution |  | 48. Signature of other institution  |  |
| 49. Signature of other institution |  | 50. Signature of other institution |  | 51. Signature of other institution |  | 52. Signature of other institution  |  |
| 53. Signature of other institution |  | 54. Signature of other institution |  | 55. Signature of other institution |  | 56. Signature of other institution  |  |
| 57. Signature of other institution |  | 58. Signature of other institution |  | 59. Signature of other institution |  | 60. Signature of other institution  |  |
| 61. Signature of other institution |  | 62. Signature of other institution |  | 63. Signature of other institution |  | 64. Signature of other institution  |  |
| 65. Signature of other institution |  | 66. Signature of other institution |  | 67. Signature of other institution |  | 68. Signature of other institution  |  |
| 69. Signature of other institution |  | 70. Signature of other institution |  | 71. Signature of other institution |  | 72. Signature of other institution  |  |
| 73. Signature of other institution |  | 74. Signature of other institution |  | 75. Signature of other institution |  | 76. Signature of other institution  |  |
| 77. Signature of other institution |  | 78. Signature of other institution |  | 79. Signature of other institution |  | 80. Signature of other institution  |  |
| 81. Signature of other institution |  | 82. Signature of other institution |  | 83. Signature of other institution |  | 84. Signature of other institution  |  |
| 85. Signature of other institution |  | 86. Signature of other institution |  | 87. Signature of other institution |  | 88. Signature of other institution  |  |
| 89. Signature of other institution |  | 90. Signature of other institution |  | 91. Signature of other institution |  | 92. Signature of other institution  |  |
| 93. Signature of other institution |  | 94. Signature of other institution |  | 95. Signature of other institution |  | 96. Signature of other institution  |  |
| 97. Signature of other institution |  | 98. Signature of other institution |  | 99. Signature of other institution |  | 100. Signature of other institution |  |

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5991  
Registered No.

520  
50 5991  
BIRTH NO.

|  |                                    |   |   |
|--|------------------------------------|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <i>James Fenwick</i>  |                                    | 2. DATE OF DEATH <i>7/4/50</i>  |   |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                    | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <i>md</i> B. COUNTY |   |
| B. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION <i>Bar. Wil-Ba Convalescent Home</i> |                                    | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 27-15</i>                |   |
| D. STREET ADDRESS (If rural, give location)<br><i>2101 Cold Spring Lane</i>  |                                    | E. LENGTH OF stay in Baltimore <i>10 yrs</i>  |   |
| 5. SEX<br><i>Male</i>  | 6. COLOR OR RACE<br><i>Colored</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><i>Widowed</i>   | 8. DATE OF BIRTH<br><i>4/14/1873</i>  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Self Employed</i>                                  |                                    | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Grocer</i>  | 9. AGE (In years, last birthday) <i>77</i><br>If Under 1 Year Months: Days<br>If Under 24 Hours Hours: Min. |
| 13. FATHER'S NAME<br><i>unknown</i>  |                                    | 11. BIRTHPLACE (State or foreign country)<br><i>St Marys County, Md.</i>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, oo or oookown) <i>no</i>  |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><i>unknown</i>  |   |
| 16. SOCIAL SECURITY NO.  |                                    | 14. MOTHER'S MAIDEN NAME<br><i>unknown</i>  |   |
| 17. INFORMANT<br><i>Cecilia Smith</i>  |                                    | ADDRESS<br><i>114 N. Fulton</i>   |   |

|                       |  |  |                                  |
|-----------------------|--|--|----------------------------------|
| MEDICAL CERTIFICATION | 18. <i>352X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | CAUSE OF DEATH   | INTERVAL BETWEEN ONSET AND DEATH |
|                       | ANTECEDENT CAUSES  | (A) <i>Uremic coma due to</i><br><i>Anuria due to</i><br><i>suspected paralysis of</i><br><i>bladder</i> |                                  |
|                       | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  | (B) <i>Heniplegia 1 year ago</i>   |                                  |
|                       | II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  | (C)  |                                  |

|  |   |  |  |  |  |
|--|---|--|--|--|--|
| 19A. DATE OF OPERATION <i>0</i>  |   | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |  |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?<br><i>fr</i>                                  |  |  |  |
| 22. I hereby certify that I attended the deceased <i>from Oct July 4, 1950 to</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>July 4, 1950</i> , and that death occurred at <i>12:30</i> m., from the causes and on the date stated above. |   |  |  |  |  |
| 23A. SIGNATURE<br><i>K. Traugott</i>   |   | 23B. ADDRESS<br><i>1623 E. N. Avenue</i>                                 |  | 23C. DATE SIGNED<br><i>7/7/1950</i>                                      |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   | 24B. DATE<br><i>July 8/50</i>   | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Mt Calvary Cem.</i>             |  | 24D. LOCATION (City, town, or county) (State)<br><i>A. A. County Md</i>  |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><i>JUL 8 - 1950</i>  |   | REGISTRAR'S SIGNATURE<br><i>Winston Williams, M.D.</i>                   |  | 25. FUNERAL DIRECTOR<br><i>Mrs. Arthur A. Elliott &amp; Daughter</i>     |  |

*1129 N. Caroline St*  
*135B*

CERTIFICATE OF DEATH

1. Name of deceased

2. Date of death

3. Place of death

4. Cause of death

5. Signature of physician

6. Signature of registrar

7. Signature of informant

8. Signature of witness

9. Signature of funeral director

10. Signature of undertaker

11. Signature of cemetery

12. Signature of burial

563

0 5992

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5992

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Robert J. Dunworth

2. DATE  
OF  
DEATH

July 7, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland BALTIMORE

4. USUAL RESIDENCE (Where deceased lived, institution: residence  
A. STATE MARYLAND B. COUNTY before admission)B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

1519 ENSOR ST

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
BALTIMORE 9-09 township)

D. STREET ADDRESS (If rural, give location)

1519 ENSOR ST.

C. Length of stay in Baltimore

41 Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

April 27, 1884

9. AGE (In years  
last birthday)

66

If Under 1 Year  
Months: Days

3 10

If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Labor Water Dept. Balto City

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ireland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Dunworth

14. MOTHER'S MAIDEN NAME

Margaret Galvin

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Elizabeth M. Dunworth 1519 Ensor St

ADDRESS

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Coronary thrombosis  
DUE TO

4 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Antineoplastic C-V disease  
DUE TO

1 year

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK22. I hereby certify that I attended the deceased from June 12, 1950, to July 7, 1950, that I last saw the  
deceased alive on June 6, 1950, and that death occurred at 3:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE

H. W. D. Thompson

M. D.

23B. ADDRESS

1520 E. 33rd St.

23C. DATE SIGNED

7-7-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7-10-50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Cemetery Baltimore Md

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

JUL 8 - 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Edmund W. Conklin 924 E. Eager St.

ADDRESS

VS 150

9705F

5992

937

MEDICAL CERTIFICATION

1011 Granger  
15208.33 At.

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 5993**

BIRTH NO.

|  |                                    |  |                                      |
|--|------------------------------------|--|--------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Sarah Susie Dickens</b>  |                                    | 2. DATE OF DEATH <b>July 5, 1950</b>   |                                      |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland  |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY |                                      |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>JOHNS HOPKINS HOSPITAL</b>                                       |                                    | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore 18-02</b>                 |                                      |
| 6. LENGTH OF STAY IN BALTIMORE   |                                    | D. STREET ADDRESS (If rural, give location)<br><b>1202 W. Franklin St.</b>   |                                      |
| 7. SEX<br><b>Female</b>  | 8. COLOR OR RACE<br><b>Colored</b> | 9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>  | 10. DATE OF BIRTH<br><b>12-25-95</b> |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b> |                                    | 12. AGE (in years last birthday) <b>54</b>   |                                      |
| 13. FATHER'S NAME  |                                    | 14. BIRTHPLACE (State or foreign country)<br><b>Va.</b>  |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>                                     |                                    | 16. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                      |
| 17. SOCIAL SECURITY NO.  |                                    | 18. MOTHER'S MAIDEN NAME<br><b>?</b>   |                                      |
| 19. INFORMANT  |                                    | ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>   |                                      |

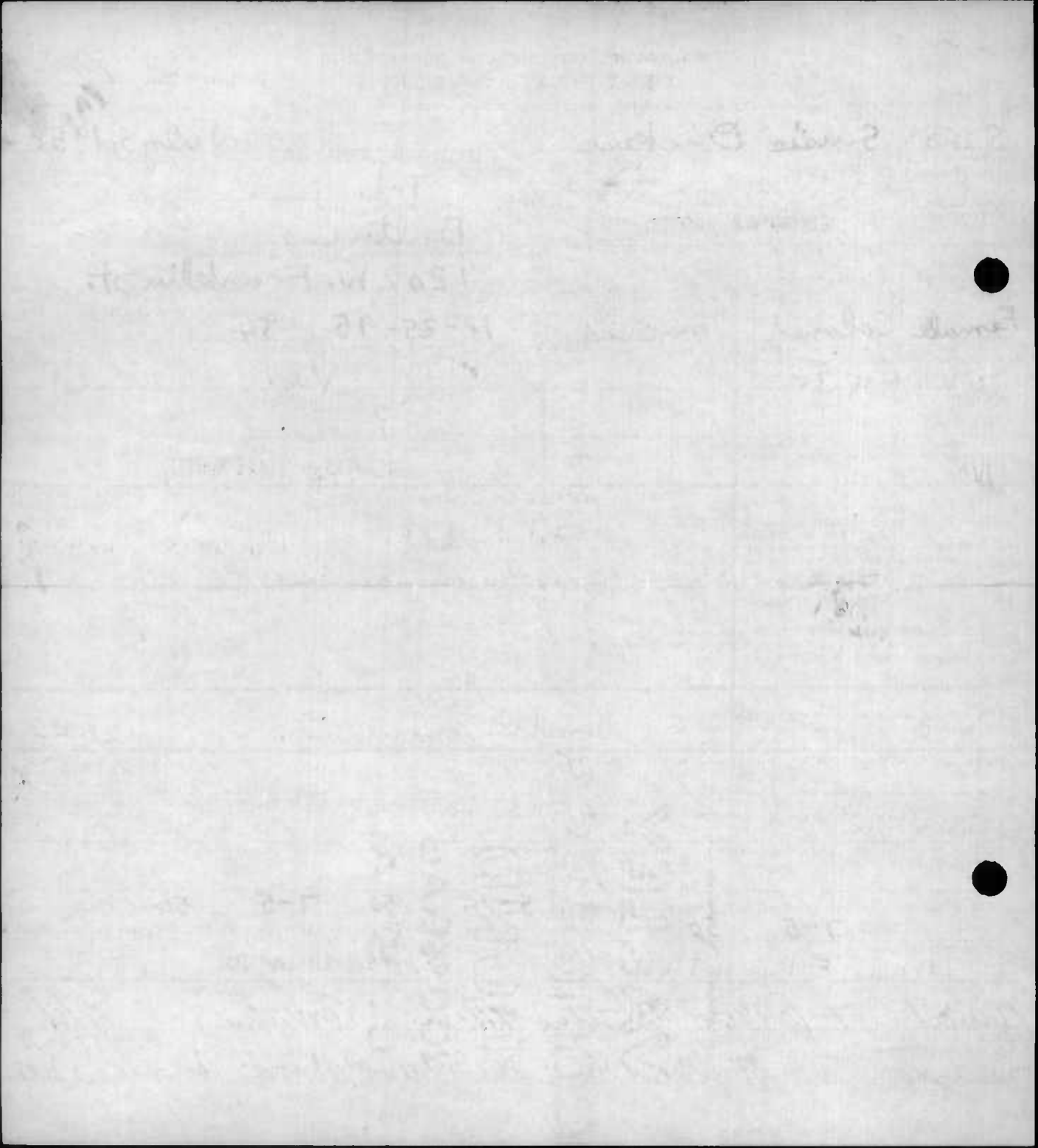
|  |  |  |
|--|--|--|
| 18. <b>443X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic and hypertensive cardiovascular disease</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Unknown</b> |
| DUE TO   |  |  |
| ANTECEDENT CAUSES  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |  |  |
| DUE TO   |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>Dermatitis medicamentosa</b>   |  | <b>2 WEEKS</b>                                     |

|  |  |  |  |   |
|--|--|--|--|---|
| 19A. DATE OF OPERATION<br><b>0</b>   |  | 19B. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |   |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |   |
| 22. I hereby certify that I attended the deceased from <b>5-25</b> , 19 <b>50</b> , to <b>7-5</b> , 19 <b>50</b> that I last saw the deceased alive on <b>7-5</b> , 19 <b>50</b> , and that death occurred at <b>6:40 P.M.</b> , from the causes and on the date stated above. |  |  |  |   |
| 23A. SIGNATURE<br><b>Thomas E. Baker, M.D.</b>   |  | 23B. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>                            |  | 23C. DATE SIGNED<br><b>6-21-50</b>  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 24B. DATE<br><b>7-10-1950</b>  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Arboretus Mem.</b>              | 24D. LOCATION (City, town, or county) (State)<br><b>Arboretus Md</b> |   |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 8 - 1950</b>  |  | REGISTRAR'S SIGNATURE<br><b>Timothy R. Williams, M.D.</b>                |  | 25. FUNERAL DIRECTOR<br><b>Mrs. Katie R. Williams</b>                               |
|  |  | ADDRESS<br><b>Schroeder St.</b>  |  |   |

MEDICAL CERTIFICATION

937





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 5994

BIRTH NO.

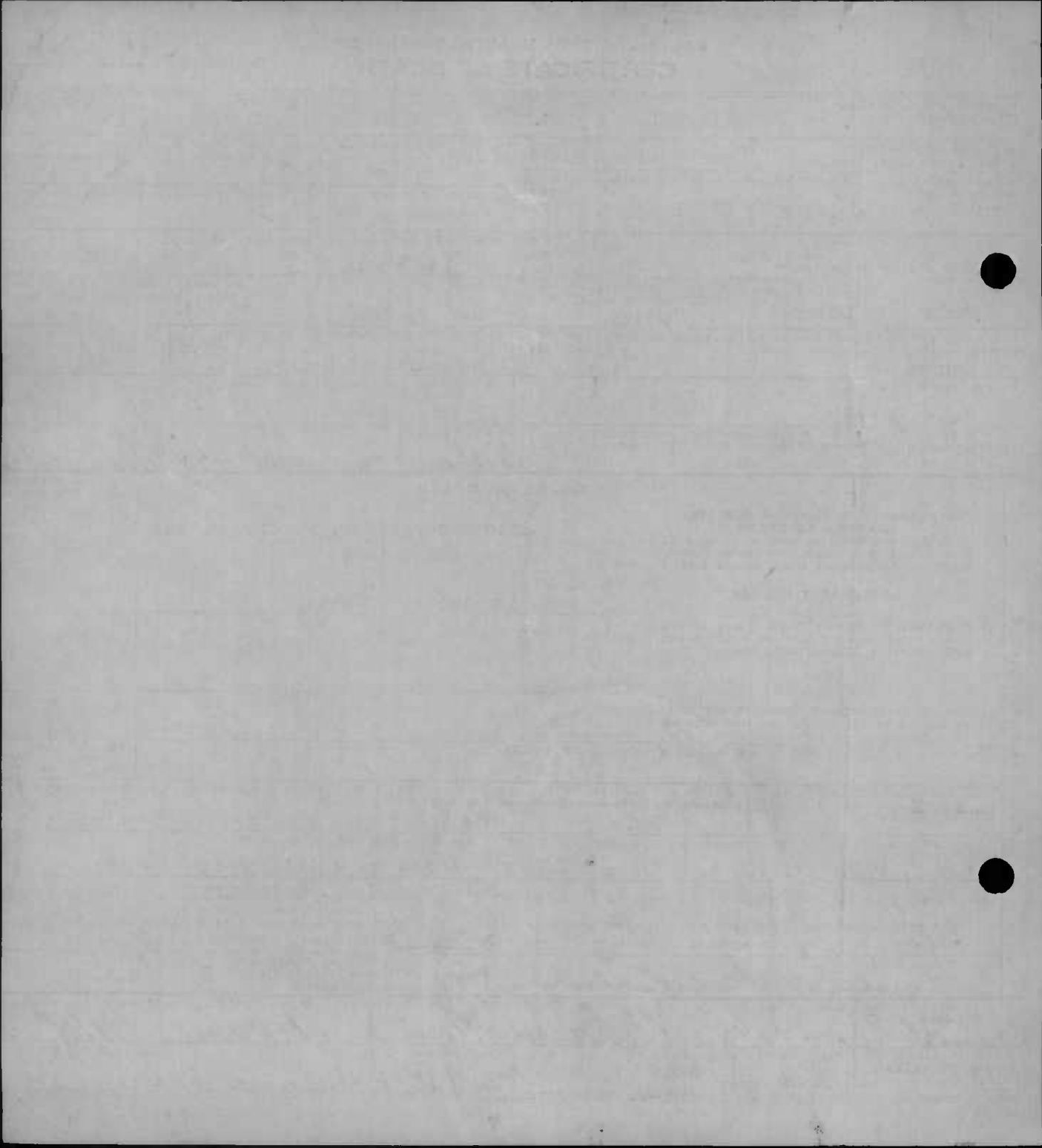
|   |                                    |  |  |
|---|------------------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>ELIZABETH M. CULVER</b>   |                                    | 2. DATE OF DEATH <b>July 5, 1950</b>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                    | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>Anne Arundel</b> |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital</b>  |                                    | C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)<br><b>Jessups</b>  |  |
| Length of stay in Baltimore<br>Yrs. _____ Mos. _____ Days _____   |                                    | D. STREET ADDRESS (If rural, give location)<br><b>5099 UPS 5200</b>  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Colored</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>  | 8. DATE OF BIRTH<br><b>June 7, 1895</b>      |
| 9. AGE (In years last birthday)<br><b>55</b>  |                                    | If Under 1 Year<br>Months: _____ Days: _____   | If Under 24 Hours<br>Hours: _____ Min. _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>       |                                    | 10B. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Anne Arundel County, Md.</b>  |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>James Garrett</b>   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Rittie Edwards</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b> |                                    | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT<br><b>William Hammond</b>   |                                    | ADDRESS<br><b>644 Melrose St.</b>  |  |

|  |  |                                  |
|--|--|----------------------------------|
| 18. <b>E 816.4</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Multiple lacerations, fractures, and contusions</b><br>DUE TO |  | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Crushing injury of chest</b><br>DUE TO  |  |                                  |
| (C)  |  |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |                                  |

|  |   |   |  |   |
|--|---|---|--|---|
| 19A. DATE OF OPERATION <b>July 5, 1950</b>   |   | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Road</b>           | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>Airport Road near Friendship Airport</b> |  | 21F. HOW DID INJURY OCCUR?<br><b>Three car collision (passenger)</b>                |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY<br><b>July 5, 1950 12:20 A.m.</b>  | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> |   |  |   |

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

|  |   |  |  |                                   |
|--|---|--|--|-----------------------------------|
| 23A. SIGNATURE<br><b>Stanley B. Durlacher</b> M.D.         |   | 23B. CHIEF MEDICAL EXAMINER.....<br>ASSISTANT MEDICAL EXAMINER.....<br>MEDICAL INVESTIGATOR..... |  | 23C. DATE SIGNED<br><b>7-5-50</b> |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24B. DATE<br><b>7-9-1950</b>                        | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial</b>                                    | 24D. LOCATION (City, town, or county) (State)<br><b>Arbutus Md</b> |                                   |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 8 - 1950</b>    | REGISTRAR'S SIGNATURE<br><b>Thurington Williams</b> | 25. FUNERAL DIRECTOR<br><b>Mrs. Kate R. Williams</b>   |  | ADDRESS<br><b>Schroeder St.</b>   |



300

## CERTIFICATE CORRECTED

7-12-50

50

5995

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

James Reed

2. DATE  
OF  
DEATH

July 6, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street address or location)  
JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)  
Washington, D.C.

D. STREET ADDRESS (If rural, give location)

560 N. Pittsburgh Ave.

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)Yrs.  
Mos.  
Days

Male

Colored

Single

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

8. DATE OF BIRTH

1-11-49

9. AGE (In years last birthday)

1 and 6

11 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

D.C.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

James Reed, SR

14. MOTHER'S MAIDEN NAME

Pauline Lee

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18. 010X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Tuberculous Meningitis

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Pulmonary Tuberculosis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

22. I hereby certify that I attended the deceased from 2-25, 1950, to 7-6, 1950 that I last saw the deceased alive on 7-6, 1950, and that death occurred at 7:40 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Leonard F. Rosenberg M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

7 July 50

24A. BURIAL, CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 8 - 1950

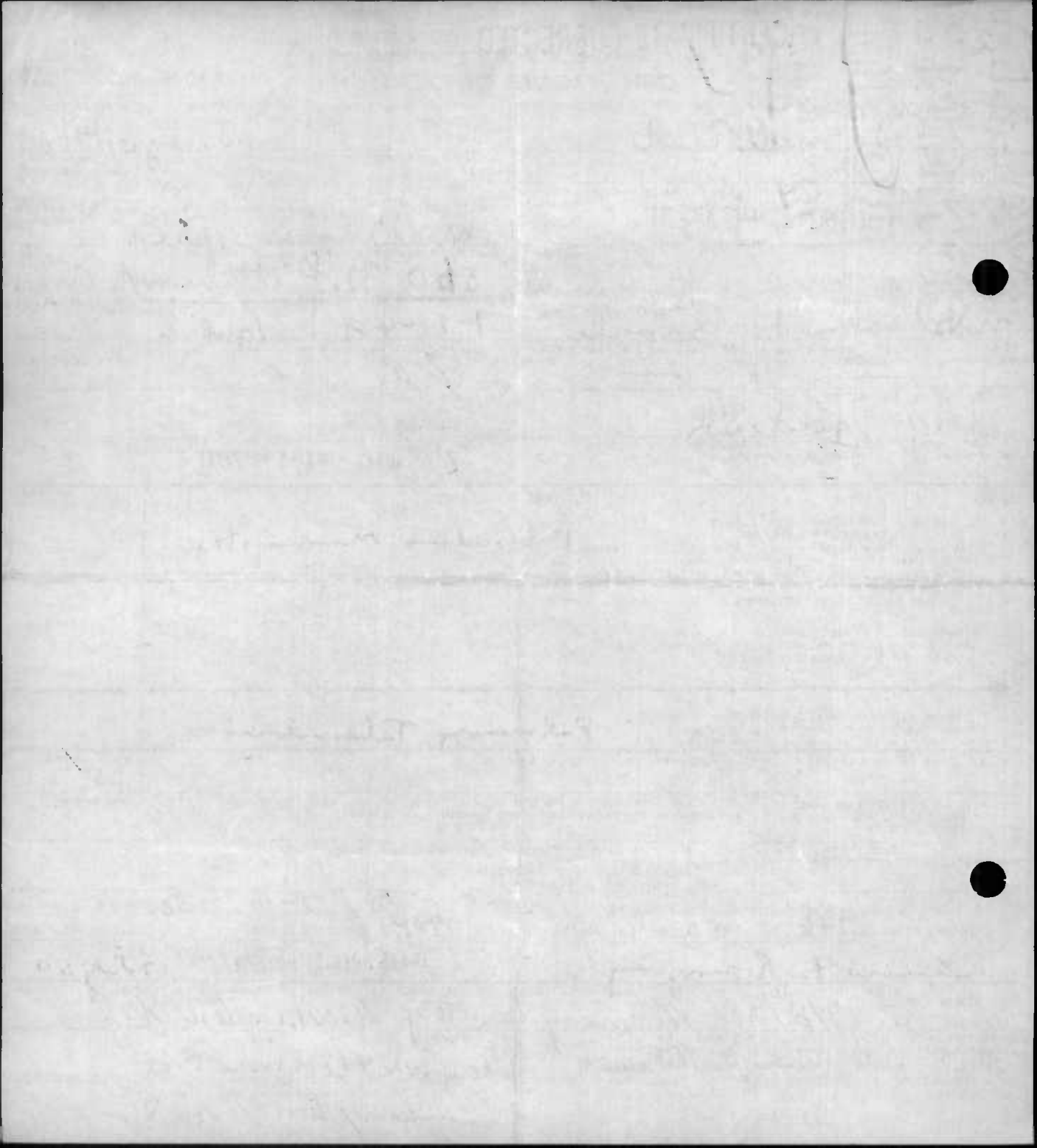
Tunington Williams, M.D.

Cornish &amp; Cornish Co

VS 150

Washington, D.C., 130

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5996  
Registered No. \_\_\_\_\_

462  
50 5996  
BIRTH NO. \_\_\_\_\_

|   |                                  |  |   |  |  |
|---|----------------------------------|--|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>MARGUERITE MARIE CLARK</b>  |                                  |  | 2. DATE OF DEATH<br><b>July 7, 1950</b>   |  |  |
| 3. PLACE OF DEATH:<br>A. <b>Baltimore City, Maryland</b>  |                                  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b><br>B. COUNTY _____ |  |  |
| 5. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION <b>623 Edgewood St.</b> |                                  |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>                                |  |  |
| 6. LENGTH OF STAY IN BALTIMORE<br>Yrs. _____<br>Mos. _____<br>Days _____<br><b>life</b>   |                                  |  | D. STREET ADDRESS (If rural, give location)<br><b>623 Edgewood St.</b>  |  |  |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Divorced</b> | B. DATE OF BIRTH<br><b>June 11, 1898</b>  |  | 9. AGE (in years last birthday)<br><b>52</b>                 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clerk-Accounting</b>                  |                                  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b> |
| 12. CITIZEN OF WHAT COUNTRY?<br>_____   |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>Louise Steinmiller</b>   |  |  |
| 13. FATHER'S NAME<br><b>McEvoy</b>  |                                  |  | 17. INFORMANT ADDRESS<br><b>St. Mr. Benjamin Edward Clark, Jr. 623 Edgewood</b>   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>no</b>  |                                  |  | 16. SOCIAL SECURITY NO. _____   |  |  |

|  |  |  |
|--|--|--|
| 18. <b>171X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Carcinomatous (Abdominal)</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Feb. 1949</b> |
| DUE TO<br><b>Carcinoma Cervix.</b>   |  |  |
| DUE TO<br>_____  |  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>(B) _____<br>(C) _____   |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>_____   |  |  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 19A. DATE OF OPERATION<br><b>none</b>   |  | 19B. MAJOR FINDINGS OF OPERATION<br>_____   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br>_____        |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>_____ |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY<br>_____   |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?<br>_____   |  |
| 22. I hereby certify that I attended the deceased from <b>Feb. 4, 1949</b> to <b>July 6, 1950</b> , that I last saw the deceased alive on <b>July 5, 1950</b> , and that death occurred at <b>9 P. M.</b> , from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE<br><b>George E. Shannon</b>  |  | 23B. ADDRESS<br><b>20 Medical Sts Bldg.</b>   |  | 23C. DATE SIGNED<br><b>July 7, 1950</b>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>7/10/50</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Western Cem.</b>                         |  |
| 24D. LOCATION (City, town or county)<br><b>Baltimore, Md.</b>   |  | 24E. DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 8 - 1950</b>  |  |   |  |
| REGISTRAR'S SIGNATURE<br><b>Huntington Williams, M.D.</b>   |  | 25 FUNERAL DIRECTOR ADDRESS<br><b>Wm. J. Lickner &amp; Sons Balto Md.</b>                                 |  |   |  |

VS 150  
310 50 5996  
48a md.

MEDICAL CERTIFICATION



By order of the Board of Directors, 1900

Secretary (Signature)

1900

Secretary (Signature)

1900

Secretary (Signature)

635

50 5997

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 5997

|   |  |   |  |
|---|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>George Worthman</i>   |  | 2. DATE OF DEATH <i>July 6/50</i>   |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland <i>2027 Ellsworth</i>                                   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>md</i> B. COUNTY <i>Balto.</i> |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><i>Baltimore 8-07</i>                               |  |
| D. STREET ADDRESS (If rural, give location)<br><i>2027 Ellsworth St</i>                                   |  | E. LENGTH OF STAY IN BALTIMORE<br><i>70 Yrs. Mos. Days</i>  |  |
| 5. SEX <i>Male</i>  | 6. COLOR OR RACE <i>White</i>                    | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>  | 8. DATE OF BIRTH <i>July 6/1879</i>        |
| 9. AGE (In years last birthday) <i>70</i>   | 10. UNDER 1 Year Months: <i>6</i> Days: <i>6</i> | 11. BIRTH PLACE (State or foreign country) <i>Baltimore</i>   | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Career</i> |  | 10B. KIND OF BUSINESS OR INDUSTRY <i>Grocery Store</i>  |  |
| 13. FATHER'S NAME <i>Ernest Worthman</i>  |  | 14. MOTHER'S MAIDEN NAME <i>Mrs. M. M. M.</i>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>                               |  | 16. SOCIAL SECURITY NO. <i>no</i>   |  |
| 17. INFORMANT <i>Mrs. Katherine C. Worthman</i>   |  | ADDRESS   |  |

|   |                                     |                                  |
|---|-------------------------------------|----------------------------------|
| 18. <i>444X</i>   | CAUSE OF DEATH                      | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) <i>acute congestive failure</i> |                                  |
| ANTECEDENT CAUSES   | (B) <i>Hypertension</i>             |                                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   | (C) <i>Diabetes mellitus</i>        |                                  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                                     |                                  |

|  |  |  |
|--|--|--|
| 19A. DATE OF OPERATION <i>0</i>  | 19B. MAJOR FINDINGS OF OPERATION   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>    |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)   | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY   | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |
| 22. I hereby certify that I attended the deceased from <i>July 3, 1950</i> , to <i>July 6, 1950</i> , that I last saw the deceased alive on <i>July 6, 1950</i> , and that death occurred at <i>11:45 p.m.</i> , from the causes and on the date stated above. |  |  |
| 23A. SIGNATURE <i>Louis R. Maer</i>  | 23B. ADDRESS <i>4335 Park Heights Ave</i>  | 23C. DATE SIGNED <i>July 7/1950</i>                                      |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>  | 24B. DATE <i>July 10/1950</i>  | 24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore Cem.</i>                 |
| 24D. LOCATION (City, town, or county) <i>North Ave &amp; Gay St.</i>   | 24E. (State)   |  |
| DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 8 - 1950</i>   | REGISTRAR'S SIGNATURE <i>Wm. M. Williams, M.D.</i>   | 25. FUNERAL DIRECTOR <i>Geo M. Frick &amp; Son</i>                       |
| ADDRESS  |  |  |

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
OFFICE OF THE CHIEF, BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

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630

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5998

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)*John Spence Howard*2. DATE  
OF  
DEATH*July 7, 1950*

3. PLACE OF DEATH

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

*Maryland*

B. COUNTY

*Baltimore*5. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION*Union Memorial Hospital*

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

*Baltimore*

D. STREET ADDRESS (If rural, give location)

*1122 N. Calvert St.*

6. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

*M*

6. COLOR OR RACE

*W*7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)*married*

8. DATE OF BIRTH

*April 19, 1884*9. AGE (In years;  
last birthday)*66*10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)*Civil Engineer*10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

*Maryland*12. CITIZEN OF  
WHAT COUNTRY?*U.S.A.*

13. FATHER'S NAME

*John Spence Howard*

14. MOTHER'S MAIDEN NAME

*Mary Eliza Hodges*15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

*Janette Howard**same as deceased*18. *420.0*

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

*myocardial infarction**2 hours*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

*Coronary occlusion**2 hours*

DUE TO

(C)

*Hypertensive arteriosclerotic heart disease**years*

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *July 7*, 19*50*, to *July 7*, 19*50*, that I last saw the  
deceased alive on *July 7*, 19*50*, and that death occurred at *11:35 a.m.*, from the causes and on the date stated above.

23A. SIGNATURE

*Dr. F. Cox 3rd*

M. D.

23B. ADDRESS

*Union Memorial Hospital*

23C. DATE SIGNED

*7-7-50*24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)*burial*

24B. DATE

*7 - 9 - 50*

24C. NAME OF CEMETERY OR CREMATORY

*Trinity Church*

24D. LOCATION (City, town, or county)

*St. Mary's City, Md.*

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Wilmington Williams, M.D.*

25. FUNERAL DIRECTOR

ADDRESS

*John O. Mitchell & Sons, Inc. - 1900 Eutaw Pl.**Wm. B. Mitchell*

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

WATER RIGHTS

WATER RIGHTS

1/1

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 5999

Registered No. \_\_\_\_\_

|   |                                  |   |  |  |  |
|---|----------------------------------|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Howard Crosby Erdman</b>  |                                  |   | 2. DATE OF DEATH<br><b>July 7, 1950</b>  |  |  |
| 3. PLACE OF DEATH:<br>A. Baltimore City, Maryland   |                                  |   | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>none</b> |  |  |
| B. FULL NAME OF HOSPITAL OR INSTITUTION <b>1800 Ensor St. (Greenmount Cemetery)</b>   |                                  |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b>   |  |  |
| C. Length of stay in Baltimore <b>life</b> Yrs. Mos. Days   |                                  |   | D. STREET ADDRESS (If rural, give location)<br><b>1800 Ensor St. (Greenmount Cemetery)</b>   |  |  |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>married</b> | 8. DATE OF BIRTH<br><b>June 15, 1877</b>   | 9. AGE (In years last birthday)<br><b>73</b> | 10. Under 1 Year Months Days 11. Under 24 Hours Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Ass't. Superintendent</b> |                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Greenmount Cemetery</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>               |
| 13. FATHER'S NAME<br><b>Frederick Erdman</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth (?) Reed</b>  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                    |                                  | 16. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS<br><b>Mrs. Jennie R. Erdman 1800 Ensor St.</b>   |  |  |

|  |  |                                  |
|--|--|----------------------------------|
| 18. <b>443X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cardiac Insufficiency</b><br>(A) DUE TO |  | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Hypertensive U. Disease</b><br>(B) DUE TO   |  |                                  |
| (C) DUE TO   |  |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |                                  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 19A. DATE OF OPERATION <b>0</b>   |  | 19B. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |  |
| 21D. TIME (Month) (Day) (Year) (Hour) INJURY  |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I hereby certify that I attended the deceased from <b>3/22</b> , 19 <b>49</b> to <b>7/7</b> , 19 <b>50</b> that I last saw the deceased alive on <b>7/7</b> , 19 <b>50</b> and that death occurred at <b>24</b> m., from the causes and on the date stated above. |  |   |  |   |  |
| 23A. SIGNATURE<br><b>Samuel L. Green</b><br>M. D.   |  | 23B. ADDRESS<br><b>1261 E. North Ave.</b>   |  | 23C. DATE SIGNED<br><b>7/7/50</b>   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>  |  | 24B. DATE<br><b>7 - 10 - 50</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount</b>                             |  |
| 24D. LOCATION (City, town, or county)<br><b>Baltimore, Md.</b>  |  | (State)   |  |   |  |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>                                 |  | 24B. DATE<br><b>7 - 10 - 50</b>                       |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount</b>   |  |
| 24D. LOCATION (City, town, or county)<br><b>Baltimore, Md.</b>                             |  | (State)   |  |   |  |
| DATE RECEIVED BY LOCAL REGISTRAR<br><b>JUL 8 - 1950</b>                                    |  | REGISTRAR'S SIGNATURE<br><b>Wm. H. Williams, M.D.</b> |  | 25. FUNERAL DIRECTOR ADDRESS<br><b>John O. Mitchell &amp; Sons, Inc. - 1900 Eutaw Pl.</b><br><b>Wm. H. Mitchell</b> |  |
| VS 150<br><b>29074 Dr. Samuel L. Green 1-2 P.M.</b> <span style="float: right;">937</span> |  |   |  |   |  |

MEDICAL CERTIFICATION



July 1, 1960

Dear Mr. [illegible]

I am writing to you

in regard to the [illegible]

of the [illegible]

and the [illegible]

of the [illegible]

of the [illegible]

Sincerely,

[illegible]

Very truly yours,

[illegible]

[illegible]

156

6000

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6000

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mary E. Hoffmeyer

2. DATE  
OF  
DEATH

July 6/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR  
INSTITUTION 6 S. Catherine St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

STATE  
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6 S. Catherine St.

E. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

widow

8. DATE OF BIRTH

Aug. 29, 1893

9. AGE (in years last birthday)

56

10. Under 1 Year

Months: Days:

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

W.

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Maurice Heddinger

14. MOTHER'S MAIDEN NAME

Carrie Hecht

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Dorothy Riley, 6 S. Catherine St.

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of rectum.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

Metastasis of carcinoma to liver and pancreas.  
Diabetes mellitus

INTERVAL BETWEEN ONSET AND DEATH

About

4 yrs.

4 months

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

11/11/46

19B. MAJOR FINDINGS OF OPERATION

Carcinoma of rectum (Colostomy).

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from October, 1946, to July 6, 1950, that I last saw the deceased alive on July 6, 1950, and that death occurred at 11:30 m., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

516 Cathedral St.

23C. DATE SIGNED

7/7/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

July 10/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park, 3801 Frederick Rd. Balto. 29, Md.

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 8 - 1950

W. H. Williams, M.D.

Harry N. Wright

4101 Edmondson Ave.

